QUALITY SERVICE REVIEW

PROTOCOL FOR USE BY CERTIFIED REVIEWERS

A REUSABLE GUIDE FOR A CHILD/FAMILY - BASED REVIEW OF LOCALLY COORDINATED CHILDREN'S SERVICES

FIELD USE VERSION – 5.0

PREPARED FOR AND LICENSED TO
THE INDIANA DEPARTMENT OF CHILD SERVICES
BY
HUMAN SYSTEMS AND OUTCOMES, INC.

REVISED BY THE INDIANA DEPARTMENT OF CHILD SERVICES:
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INTRODUCTION TO THE QUALITY SERVICE REVIEW

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Provided below is the table of contents for this QSR Protocol. In addition to these materials, reviewers are provided a set of working papers that are used for reference and job aids for particular tasks (e.g., reviewer agreement checks) conducted during the review.

QUALITY SERVICE REVIEW FOR CHILDREN/YOUTH AND FAMILIES

The Quality Service Review (QSR) is an action-oriented learning process that provides a way of knowing what is working or not working at the point of practice and why for selected children and families receiving services. QSR is used to guide next step actions of practice development and local capacity building, leading to better results for children/youth and families. This protocol is designed for use in a case-based QSR process developed by Human Systems and Outcomes, Inc. (HSO) and modified by the Indiana Department of Child Services. It is used for conducting a guided professional appraisal of the: • Status of a focus child/youth receiving services; • Status of the parent/caregiver; and • Adequacy of performance of key service system practices and capacities used for the focus child and family. The protocol examines recent results for a focus child/youth and his/her parents/caregiver and the contribution made by local service providers in the system of care in producing those results. Case review and other findings are used by local agency leaders and practice managers in stimulating and supporting efforts to improve services for children/youth who are beneficiaries of the local community's system of care that provides child welfare, health, mental health, education, juvenile justice, and other services.

These working papers, collectively referred to as the *QSR Protocol*, are used to support a professional appraisal of child status and system of care performance for individual children and their parents/caregivers in a specific service area and at a given point in time. This protocol is not a traditional measurement instrument. It is a practice appraisal organizer that achieves high levels of inter-rater reliability when used by well-trained, certified reviewers. Localized versions of quality service review protocols are prepared for and licensed to child-serving agencies for their use. The QSR is based on a body of work by Ray Foster, PhD and Ivor Groves, PhD, the Principals of HSO.

Proper use of the *QSR Protocol* and other QSR working papers requires reviewer training, qualification, and supervision. Supplementary materials provided during training are necessary for reviewer use during case review and reporting activities.

ACKNOWLEDGEMENTS

DESIGN TEAM PARTICIPANTS

Listed below are the members of Indiana's advisory group who served as members of a Design Team for creating a working version of this Quality Services Review Protocol and review process. They participated in a three-day design session in January 2007 that resulted in the basic protocol design that is being pilot tested, refined, and used for baseline measurement of practice performance. Knowledge gained from the review process will be used for the positive purposes of practice development and capacity building necessary to improve the quality of practice and to achieve better results and outcomes for the children and families receiving services.

This activity was undertaken at the request of and under the direction of **James Payne**, Director of the Indiana Department of Child Services (DCS). Persons who participated in the design activities were:

1. **Pat Brown**, DCS Clark County Director
2. **Char Burkett-Sims**, DCS Regional Manager
3. **Steven Cox**, DCS Randolph County Director
4. **Gina Eckart**, Indiana Department of Mental Health and Addictions Assistant Director
5. **Gail Folaron**, Indiana University School of Social Work
6. **Lisa Goldberg Mitton**, Youth Emergency Services Program Supervisor
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Persons providing technical support and consultation for the design team process as well as for the QSR Protocol development, reviewer training, and pilot testing efforts were:

14. **Ray Foster**, Design Team Facilitator and Protocol Developer, Human Systems and Outcomes, Inc.
15. **Kate Gibbons**, Design Team Scribe and Reporter, Human Systems and Outcomes, Inc.
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Special acknowledgement for supplemental work on the Cultural Recognition indicator:

18. **Khadija Khaja**, Faculty of Social Work, Indiana University

REVISION PARTICIPANTS

In June 2009, the members listed below were brought together to revise and update the exiting language in the protocol to fit more closely with the Indiana Department of Child Service practice model. Persons who participated in the revision activities include:

1. **Valerie Bruce,** Quality Assurance Analyst
2. **Steven Cox**, DCS Regional Manager
3. **Angela Green**, DCS Deputy Director of Practice Support
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FRAMEWORK FOR CHILD WELFARE SERVICES

PREAMBLE: Our practice principles were developed with the core understanding that all decisions will be made with the primary consideration for child/youth safety.

PURPOSE: To provide an overview of principles of the Indiana Department of Child Services (DCS). This framework provides a vision for practice, outlines policy, and clarifies behavioral expectations necessary to improve our practice.

GOALS FOR INDIANA'S CHILDREN/YOUTH AND FAMILIES

1. To protect children from abuse and neglect.
2. To support families in identifying and using their inherent strengths and the resources in their community to resolve the conditions that led to abuse and neglect.
3. To affect permanent change that enhances the safety, permanency, and well-being of children and families.
4. To maintain and develop essential connections with family when children are unable to remain in their home.
5. To ensure that all children have the opportunity to achieve permanency through family preservation, family reunification, adoption, or independent living.

PRACTICE VALUES AND PRINCIPLES

The following values and principles are the standards that shall guide the child welfare system and the practice of child welfare service providers. We believe that at the core of every decision shall be the consideration of the safety and well-being of the child. We understand that the practice values and principles represent the belief that by using evidence-based methods we can best achieve the mission of the Indiana Department of Child Services. We acknowledge that the complexity of the factors contributing to child abuse and neglect presents a challenge in implementing these values and principles.

These values and principles should, therefore, govern our actions in shaping policy, hiring and training staff, resource development and contract service design, case management, supervision, and evaluating the outcomes of our efforts. To implement these principles and values, this effort will require the collaboration of children and families, staff, the court, providers, and communities.

VALUES CONCERNING CHILDREN

- Every child has the right to a safe nurturing home free from abuse and neglect.
- The most desirable place for children to grow is with their own families when these families are able to provide safe, nurturing, and stable homes.
- Vigorous early intervention services should be offered to at-risk families to enable a child to remain safely in his/her own home.
- A timely, thorough, and thoughtful response to child safety concerns is critical in effectively protecting children/youth.
- Every child has the right to appropriate care and a permanent home. The ultimate goal in permanency shall be to provide a safe and nurturing home, and for a child to develop and sustain meaningful relationships.
- Children should be in family settings. Siblings shall be placed together. Children under the age of six should never be placed in congregate care (i.e., group homes, shelter care, and institutions).
- If a child is determined to be unsafe, DCS and the family will develop a timely plan to keep the child safe, with all efforts toward services to protect the child in his/her own home.
- When children cannot live safely with their families the first consideration for placement will be with an appropriate relative in order to provide a familiar, safe, and nurturing environment to minimize loss.
- When children require out-of-home placements, careful assessment and evaluation shall be utilized when making placement decisions in an effort to promote a single placement for children.
- When children require out-of-home placements, they should maintain essential connections through frequent and meaningful contact with significant persons in their lives.
- All efforts should be made for children to remain in their own neighborhoods and maintain existing connections with families, schools, and friends.
- Reunification and permanency is accelerated when visitation between parents and children is frequent and in the most normalized environment possible.
- Success in school is more likely to occur when planning for safety, stability, and permanency is fully integrated with a child's educational plan.
- While transitioning to adulthood, children in foster care are most successful in achieving independence when they have established relationships with caring adults.

VALUES CONCERNING FAMILIES

- Parents should be empowered and given the opportunity to take responsibility for their children and resolve issues of abuse and neglect.

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- Families will be engaged with honesty, empathy, and openness. Through listening and helping, families will develop their strengths to meet current and future needs.
- Families will receive prompt and individualized service planning.
- Every person has value and worth and will be treated with honesty and dignity. Every family has strengths that can be developed.
- Family members are experts of their own families. Service planning will consider the family rules, traditions, history, and culture.
- Family perspectives, goals, and values will be regarded as critical to creating and maintaining child safety.
- To facilitate reunification, parents must be involved in treatment planning and service plan delivery, because when the strengths and voices of children/youth and families are recognized, respected, and affirmed, they are more likely to use them for change.
- Families will receive ongoing supports that will enable them to safely sustain their children in their homes.
- Families are core members of the decision-making team; therefore, decisions about child and family team interventions shall be relevant, comprehensive, and effective.
- Parents must be supported in accessing services and understand that incorporating them is necessary to improve outcomes for children.
- The family's network is essential to supporting and sustaining change. Families shall meet their needs through their own strengths and with the support of their networks.
- Coordination of the family team and accomplishment of its goal is essential and works most effectively when it occurs via regular face-to-face meetings that ensure more successful and positive outcomes.
- When children require out-of-home placement, safety must be ensured through regular and frequent contact with those children and parents.

VALUES CONCERNING COMMUNITIES

- Families and communities are responsible for ensuring that children thrive.
- DCS will work jointly with service providers who adhere to effective social work practices in the delivery of services and providers will be held responsible for demonstrating expected outcomes.
- Developing effective services is a shared responsibility best achieved by families, community partners, and public agencies working collaboratively.
- The Department of Child Services will assist families in this community/family collaboration to find resources that make children and families safe.
- Services provided to children and families will respect their cultural, ethnic, and religious heritage.
- DCS staff relationships and communications with community partners will be conducted with empathy, honesty, and openness.
- Services should be planned and developed in partnership with families and communities and provided in the least restrictive and most home-like settings.
- Concurrent planning shall begin at the commencement of CHINS proceedings.
- Services to children and families shall be planned and delivered through a straightforward, flexible individualized service plan developed by the child, family, and service team.
- Service planning implementation should be built on a comprehensive array of services designed to create the opportunity for children and families to achieve the goals of safety, well-being, and permanency.
- Strengths-based service plans are developed using a family team and a comprehensive assessment of the child and family's needs. Plans should be needs-based and should specify steps to be taken by each member of the team, timeframes for accomplishment of goals, and concrete measurements to monitor the progress of the child and family.
- Plans that are needs-based, rather than service-driven, are more likely to facilitate safety, well-being, and permanency.

These values and principles provide a basis for child welfare practice and the measurement of practice through the Quality Services Review (QSR).

A FOCUS ON PRACTICE AND RESULTS

The QSR Protocol uses an in-depth case review method and practice appraisal process to find out how children and their families are benefiting from services received and how well locally coordinated services are working for children and families. Each child and family served is a unique "test" of the service system. Samples of children are reviewed to determine child and parent/caregiver status, recent progress, and related system practice and performance results.

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QSR MEASURES PRACTICE MODELS, PRINCIPLES, CHANGE STRATEGIES, AND LOCAL CAPACITIES

QSR is a set of action research and practice advancement processes applied by practitioners to agencies that provide services to children/youth and families. A QSR Protocol is connected directly to the user's model of practice, strategies, and capacities for implementation, and measures of desired results and achievement of positive outcomes for children/youth and families receiving services.

Thus, the core content of a QSR Protocol is anchored in and designed to test practice performance, capacity, and result at the point of practice transaction. The "**practice point**" is the place where and moment when a child/youth and family in need meet and work together with people who help the family meet needs. The philosophical basis for understanding the practice point, as used here, includes the following values and beliefs:

- Practice should be child focused and family-centered. Families are full, active participants in every aspect of family change and service processes. The family provides the context for interventions with its children.
- Child and family team meetings (CFTMs) should be used to organize and support the change process for the child and family.
- The family change/service process should be individualized, culturally competent, and strengths-based to build capacities for family independence.
- Family change efforts should work toward reaching defined outcomes related to family safety, well-being, child permanency, and family independence from the service system.
- Practice should be outcome-focused and results-driven.
- Change processes should be supportive of resiliency for children/youth and supportive of recovery and relapse prevention for older youth and adults. Children should be served in their own community without having to leave their school and regular relationships for reasons of family safety or treatment.
- Family change efforts should embrace and use evidence-based practice strategies, where available and appropriate to the child/youth and family.
- Where appropriate, services for children and families should be integrated and coordinated across providers, agencies, funding sources, and settings. This includes aligning the combination and sequence of change strategies being used across all interveners in the life of the child and family into a seamless process.
- A well-integrated, coordinated service process for some families may require a service process that is inter-agency, community-based, and collaborative in operation.
- Outcomes should be routinely measured for the child, family, program, local system of care, and state-level systems. QSR is a measure of practice and results that will be used in this effort.

Design of this QSR Protocol is built upon key concepts, principles, and functions of practice.

FAMILY-CENTERED PRACTICE

PRACTICE: DEFINITION

- PRACTICE is a combination and sequence of strategies, interventions, and supports used to engage a child and family in and sustain them through a CHANGE PROCESS leading to family independence from the service system and to sustainable, safe case closure.
- PRACTICE is a FAMILY-TEAM-DRIVEN, PROBLEM-SOLVING PROCESS aimed at specific RESULTS and OUTCOMES that are set with and for the family.
- CHANGE PROCESS: Effective practice is: (1) child and family-specific, (2) need-responsive, (3) relationship-based, and (4) locally delivered strategies and service efforts. Working together, these change elements alter unacceptable situations so that child and family functioning and well-being are improved as risks of harm, avoidable hardships, and poor child and family outcomes are reduced or eliminated.

PRACTICE: FRAMEWORK

- The CENTRAL PURPOSE of practice is stimulating and supporting a successful CHANGE PROCESS leading to adequate, sustained daily functioning and well-being so that child and family independence from service system involvement is achieved.
- The ACTION IMPERATIVE of practice is FINDING WHAT WORKS in the change process during the journey of change, yielding short-term results and meeting long-term desired outcomes. This should lead to FAMILY INDEPENDENCE and SUSTAINABLE, SAFE CASE CLOSURE. Practitioners maximize a caregiver's chances of the earliest possible successes and minimize any continued exposure to risks for the child.
- FUNDAMENTAL UNDERSTANDINGS of the child and family SITUATION, family STRENGTHS/preferences, and UNDERLYING FACTORS that limit, incapacitate, or disrupt daily functioning are developed and used to plan strategies for family change. Building FUNDAMENTAL UNDERSTANDINGS is a prerequisite to change planning. Maintaining ongoing situational awareness of child and family status and a CONTINUING UNDERSTANDING OF WHAT'S WORKING/NOT WORKING are essential in guiding a family change process. Teamwork is used to form understandings

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- DEFINED ENDING POINTS are required to navigate journey of change. A LONG-TERM VIEW that sets FAMILY OUTCOMES and SUSTAINABLE, SAFE CASE CLOSURE REQUIREMENTS guides the planning of strategies for change. Successful change requires that a family select, own, and support the desired outcomes of adequate family functioning and well-being leading to independence as well as the strategies used to bring change about.

- A LONG-TERM VIEW defines FAMILY OUTCOMES for:
  - PROTECTIVE PROVISIONS put into place to keep people safe.
  - BEHAVIORAL PATTERNS to be acquired and then adequately and consistently demonstrated by the parent(s) that are necessary to preserve or reunify a family and to maintain family stability and daily functioning.
  - RECOVERY/RELAPSE PREVENTION, ADVANCE CARE DIRECTIVES, SAFETY PLANS WITH RESPONSE CAPACITIES are put in place and working reliably.
  - SUSTAINABLE FAMILY SUPPORTS (e.g., housing, health care, daycare, after-school support, employment, adequate income) are put into place to preserve and sustain the family following sustainable, safe case closure.
  - RESOLUTION OF LEGAL ISSUES AND COURT REQUIREMENTS (e.g., court orders, probation, parole, guardianship, adoption) that must be achieved before family independence, sustainable, safe case closure, and PERMANENCY can occur.
  - MEASURES AND SCHEDULES for determining progress, outcomes, and satisfaction of case closure requirements. These elements define for the family and practitioners/providers: how we will know what's working and when we're done.

Effective practice requires that planning of change processes BEGINS WITH THE END IN MIND. Clear outcomes and ending requirements provide a guiding LONG-TERM VIEW of change that helps the family and practitioners understand and agree upon what it will take to bring desired changes about.

- TRUST-BASED RELATIONSHIPS between the child and family and the practitioners/service providers are the PRIMARY MEDIUM through which psycho-social and educational change strategies (interventions) must work. Engaging family members and sustaining their commitment to the change process is essential for success. Building relationships with practice partners is key.

- Successful family changes BUILD ON FAMILY STRENGTHS and is sustained by child and family resilience, motivation, and ongoing supports of others. The family team assesses and builds on family strengths.

- SHARED DECISION MAKING VIA A TEAM PROCESS is used to support and guide the family change process. The team belongs to the family, not to any one agency. Family members invite their supporters. Practitioners from other agencies holding plans of change for the child and family also participate.

- CHANGE STRATEGIES are an agreed-upon combination and sequence of actions used to alter the underlying dynamic factors that limit, incapacitate, or disrupt adequate daily functioning and wellbeing. They also build capacities necessary for the family to achieve and sustain: (1) safety, (2) adequate daily functioning, (3) well-being, and (4) permanency. This process moves beyond matching services to needs and to MATCHING STRATEGIES TO CHANGES TO BE MADE to reach case closure requirements set in the LONG TERM VIEW.

- PRECISION & DISCIPLINE USED IN CHANGE STRATEGIES: Only strategies having a high probability of producing desired changes should be used, including EVIDENCE-BASED STRATEGIES, when available and appropriate. Strategies should be implemented with sufficient power and precision to be effective in producing expected changes. Strategies that don't work should be stopped promptly and replaced with those next most likely to succeed.

PRACTICE: CORE FUNCTIONS FOR FAMILY CHANGE

- **ENGAGING**. Building trust-based working relationships.
  - Upon child and family entry into the system, those interveners involved with the family use engagement strategies, including special accommodations with any difficult-to-reach family members, to increase family engagement and participation in the family change process.
  - Practitioners/interveners build and sustain trust-based working relationships with the child, family, and/or others to support ongoing assessment, understanding, and service decisions.
  - Practitioners/interveners rely on a mutually beneficial partnership with the child, family, and/or others to sustain their interest in and commitment to the change process.

- **TEAMING**. Teamwork provides a base for sharing, integrating, and using information, resources, strategies, actions to achieve outcomes and meet requirements for family independence and a shared LONG-TERM VIEW.

  TEAM FORMATION:

  - The people who provide support and services for this child and family form a working team that meets, talks, and plans together to support the family through a change process. Collectively, team members have the skills, family knowledge, and abilities necessary to organize effective

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services for a child and family of this complexity and cultural background.

TEAM FUNCTIONING:

- Members of the family team collectively function as a unified team in planning services and evaluating results.
- Actions of the family team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the child and family.

COORDINATING:

- A single point of coordination and leadership is necessary for convening and facilitating effective family change planning and service decision processes for this child/youth and family.
- Effective coordination, integration, and continuity in assessment, planning, organization, and provision of services are necessary to guide and adjust the family change process to find what works and to help the family become independent of the service system.

♦ **ASSESSING & UNDERSTANDING**.

CULTURAL RECOGNITION:

- Making appropriate cultural accommodations involves a set of strategies used by practitioners to individualize the service process to improve the goodness-of-fit between family members and providers who work together in the family change process. Some families require the use of more specialized and intensive accommodations and culturally competent supports in order to successfully engage, educate, assist, and support a family moving through a change process to reach family independence and sustainable, safe case closure by the system, as child welfare agencies serve an increasing portion of children and families outside the majority culture. Accommodations include valuing cultural diversity, understanding how it impacts family functioning in a different majority culture, and adapting service processes to meet the needs of culturally diverse children and their families.

ASSESSING & UNDERSTANDING:

- Through ongoing fact-finding and organization of relevant information and knowledge, the child and family team creates a shared BIG PICTURE UNDERSTANDING of the child's and family's strengths, needs, risks, and underlying dynamic factors. Understandings reveal WHAT THINGS MUST CHANGE for the child to live safely and permanently with the birth family or adoptive family, independent of agency supervision.
- Understandings are reflected in LONG-TERM VIEW REQUIREMENTS and in the CHANGE STRATEGIES used in the intervention process to help the family achieve safety, permanency, and well-being.

♦ **PLANNING**. A child and family-centered, culturally-competent, safety-focused, evidence-based, well-reasoned, planning process drives change for positive outcomes, as defined in the LONG-TERM VIEW.

LONG-TERM VIEW with conditions set for SUSTAINBLE, SAFE CASE CLOSURE:

- The child and family team formulates stated, shared, and understood outcomes for family independence and sustainable, safe case closure requirement that define the end points for the journey of family change.
- When the child and family situation meets the outcomes and sustainable, safe case closure requirements set for the change process, it means that the child and family have: (1) reached acceptable levels of stability, daily functioning, and well-being; (2) dependable protective capacities and conditions present in the home; (3) acquired, demonstrated, and sustained required behavioral changes; (4) ongoing supports in place for sustaining the family; (5) resolved outstanding legal issues, including permanency; (6) recovery, relapse prevention, and safety supports in place; and (7) completed any other requirements.
- At this end point, the child and family are READY FOR SUSTAINABLE, SAFE CASE CLOSURE and EXIT from the child welfare system. When this end point is reached, attainment of PERMANENCY can be asserted for a child who was removed for a time from entering the family for reasons of child protection. The child is now living in a safe and appropriate family situation with enduring and nurturing relationships.

CHILD AND FAMILY PLANNING:

- An ongoing child and family team process is used in selecting and managing change strategies with related interventions and supports, resources, and schedules to drive child/youth and family change processes forward to attainment of specified outcomes/ending requirements defined in the long-term view requirements.

TRANSITIONS & LIFE ADJUSTMENTS:

- The child and family team anticipates MAJOR LIFE CHANGES using transition staging, transitional supports, and follow-along tracking provided in new settings and circumstances for the child/family to assure a timely, smooth, and successful adjustment for the child and family after the change occurs.
- Transitional staging plans/arrangements are made and executed to assure a successful change process and LIFE ADJUSTMENT in daily settings during and after changes unfold, especially when a child is returning to home and school following temporary placement in foster care, treatment, or detention.

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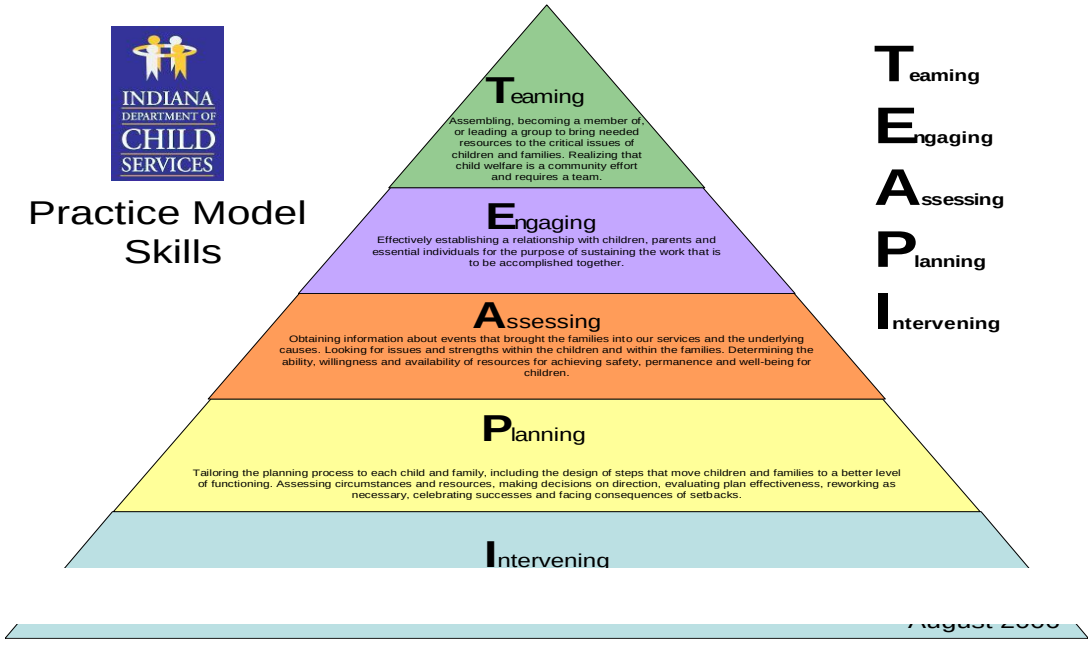

♦ **ADEQUATE INTERVENTION**. Change-related interventions, actions, and resources provided to the child and family have SUFFICIENT POWER (precision, intensity, duration, fidelity, and consistency) to produce expected short-term results and to achieve sustainable, safe case closure requirements set for the change process in the LONG-TERM VIEW.

PRINCIPLE OF PROPORTIONATE RESPONSE:

- The scope, depth, and intensity of change strategies should MATCH/FIT the size, nature, and urgency of needs presented by the situation.
- A FLEXIBLE, FUNCTIONAL RESPONSE is required. It should not be greater than required to achieve sustainable, safe case closure. A RESPONSE IS INDIVIDUALIZED to FIT the family situation. No FIXED FORMULA OR MODEL is likely to offer a unique commensurate response. This principle requires that a family team DO WHATEVER IT TAKES TO FIND WHAT WORKS.

♦ **TRACKING & ADJUSTMENT**

- Situational awareness, strategy implementation, ongoing progress and problems, and readiness for sustainable, safe case closure are tracked and evaluated by the family team to find what is working/not working for the child and family.
  - Strategies, interventions, and supports are modified in response to changing needs and used to apply knowledge gained about strategies and results to create a SELF-CORRECTING PROCESS for FINDING WHAT WORKS for the child and family.
- These key practice functions are illustrated in the display on the following page as Indiana's practice mode "TEAPI": teaming, engaging, assessing, planning, and intervening.
- QSR Protocols, such as this one, often include review indicators for specialized areas of practice that apply at some points and with some families, but not all. Such special procedures may include such functions as: crisis/safety response, medication management, transitions, cultural accommodations, and clinically based interventions for domestic violence, addiction, and mental illness.
- When conducting a "practice point review" of a child and family, the reviewer first determines the status of the child and family in key areas. Child and family status indicators include safety of the child and parent, stability, permanency, living situation, health, emotional well-being, the child's developmental or academic status, parenting capacities and challenges, availability of basic necessities and informal supports. Family progress toward independence and sustainable, safe case closure is reviewed.
- Effectiveness of key practice functions can only be understood within the context of the current status of the child and family and progress being made. Thus, child/family status, recent progress, and performance of key practice functions together create a QSR case review.

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UNDERSTANDING PRACTICE POINTS WITHIN THE CONTEXT OF LOCAL WORKING CONDITIONS

In QSR, the MICRO-VIEW of what is happening at the "practice points" where families and practitioners interact is understood within a context or MACRO-VIEW of the prevailing local working conditions of practice at the time of review. In this process, the collection of QSR case review findings provided about the sample of families is framed and interpreted within a broader understanding of present local conditions determined via focus group interviews conducted with key stakeholders. Stakeholder groups include frontline workers, supervisors, managers, parents, caregiverss, youth, providers, inter-agency partners, neighborhood/ community partners, educators, and judges. Their perspectives on current practice conditions, recent changes, current barriers and short-term opportunities for change, present working relationships, adequacy of the local system of care, and impact of recent reforms build a local context for understanding what is happening at the practice points within the service system.

QSR includes an examination of relevant quantitative data related to case-load sizes, supervision ratios, staff retention/turnover rates, availability of flexible funding, and access to essential treatment and support services. Macro-level analysis includes recognizing important changes in the size, composition, and geographic distributions of children and families as well as changing reasons for families entering and exiting the service system.

Other macro-level inquiries conducted during on-site focus group interviews can be directed at unfolding innovations or at impacts of recent policy or budget decisions on local conditions. Areas for exploration might include community-focused systemic practice. Topics discussed with key stakeholders and focus group participants could address:

- **Development of a local presence.** Because of the way in which caseloads are constructed in area offices, worker's decisions can be affected by the limited information they have about families in communities. Information reaching the DCS worker is often through the "pinhole" of an incident-based investigation and assessment phase. A local presence through geographic case assignment or visible location of workers in the neighborhood:
  - Creates opportunity for more informal contacts with families;
  - Reduces crisis-driven contacts within which the worker must exercise disproportionate power;
  - Promotes better ongoing assessment of progress on case plans as results accumulate for families; and
  - Contributes to better local knowledge of community and culture within which families live their everyday lives and must achieve their goals.
- **Teamwork accountability.** Family teams need to operate on a principle of openness to the community, its families and their concerns. Family teams, organized around individual families, should work in conjunction with an "extended team" or network. The extended team refers to a larger network of community stakeholders, local service providers, community leaders, residents, parents, concerned citizens, and others who are drawn together and constituted as a group around their commitments to improving the social conditions that face families coming to the Department's attention. (This could be the Community Connections Coalitions or other neighborhood-based family support coalitions). Their primary role is to offer parents support and a place to be heard, and to ensure communication between families and DCS.
- **Building DCS relationships with communities.** There is a legacy of mistrust of child welfare that persists in vulnerable communities where DCS does most of its work. The quality and integrity of primary relationships between direct service staff and families, and the consistency and integrity of managerial and administrative relationships that give them support, will influence successful outcomes at the "practice point." We must address situations in which families are both the source of problems and the resource to solve those problems, and to do this we must address the legacy of mistrust. DCS offices can use community-based practice partnerships and local coalitions as "bridging organizations" to gain access to community residents isolated from constructive partnerships with DCS. They can plan "open house" events inviting families to visit the office, sponsor brunches or resource fairs, and create settings for conversations between the community and the Department about their experience of the local child welfare office. The goal is to see assumptions on both sides and to unlock the opposition that goes with the "us and them" way of thinking.
- **Creating second-level change.** We need to design strategies that focus on the right order of change (second- versus first-order change). For example, a case review process points to the need for workers to engage in a more family-centered, strengths-based assessment phase, a practice change affecting the rules and relationships that exist between parents and workers. We adopt a format (e.g., QSR), and the format runs the risk of being substituted for the change in rules and relationships needing to be addressed and the process is declared a success. Workers follow the new process and use the new format, but relationships haven't changed and so practice doesn't change. This happens because we are often reluctant to create the conditions to allow a genuine second-order change to develop. CANS (Child & Adolescent Needs & Strengths assessment) is another good example of how a particular form or tool can be used to bring about first- or second-order change. Some offices are using it creatively to engage families differently; some are using it in a perfunctory manner, creating a "doubling" effect. In the latter scenario, CANS is viewed as an additional burden and done alongside practice as usual.

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- **Family empowerment and engagement as core practice.** Family group conferencing is a wonderful means to create authentic family involvement, but is limited in that it is only available to a small number of families. By using broad-based community partnership strategies, "teaming" and family teams through Family Networks, team meetings can be used variably at different points in the life of a case, to significant effect. Family members are engaged early as part of the decision-making process. Meetings can be held within short timeframes, bringing key family members to the table. The right decision at this stage is critical to make subsequent service planning and delivery be appropriately focused on outcomes for the family, not ameliorating or undoing a questionable DCS decision made because of inadequate information or without meaningful family involvement. (This may seem more related to family-centered practice; however, the core values of "family-centered" and "community-focused" are closely aligned in effective practice.)

- **Community-focused practice questions.** What did the FCM or provider agency do to demonstrate community-focused practice?

  - Did the FCM identify local resources, both informal and formal? If informal resources were not immediately identifiable, did the FCM make efforts to locate them?

  - Was the FCM consistently attentive to preserving family relationships, the most primary resource?

  - Did the FCM understand the family's problems in a way that allowed for the preservation of personal responsibility while recognizing and responding to community-level concerns that challenge the family (e.g., housing, violence, paucity of medical/dental providers, and lack of transportation)?

  - Did the FCM partner with relevant helping systems (e.g., in domestic violence cases, with law enforcement, batterer intervention, battered women's programs, etc.—practicing complimentary individual and system work)?

- **Community-focused evaluation questions.** What did the FCM or provider agency do to demonstrate community-focused practice?

- Does the local area office have a presence in the community? Is the office visible?

  - Is the DCS area office and lead agency involved with the community based practice partners (where they exist)? If not, are they involved with other local family support agencies or coalitions? How are they engaged with one another? Has the coalition been brought into the implementation of Community Partnerships or Community-Based Care Agencies? Is the coalition viewed as a resource for access to informal supports?

  - Are family teams operated in an open manner, conducive to community participation when indicated?

  - Are there forums for ongoing partnership and problem solving?

  - Are family team meetings convened at different points in the case process? Are families engaged in decision making?

Woven together, the micro-view and macro-view findings reveal what is working/not working for which kinds of children and families and what local conditions facilitate or limit practice and positive outcomes for children and families. When coupled with QSR case review findings, focus group themes and patterns, the quantitative patterns help the QSR team to triangulate findings for developing a "big picture understanding" of what is happening now and a "future view" of possible next steps that could advance practice performance, build local capacities, and get better outcomes for children and families in the future. This information is applied in next step plans and actions taken by local practitioners, managers, and community partners.

WHAT'S LEARNED THROUGH THE QSR

The QSR process involves case reviews, data pattern reviews, and interviews with key stakeholders, focus groups. Triangulated results provide a rich array of well-focused lessons for learning and next step action and improvement. QSR results include:

- Detailed stories of practice and results and recurrent themes and patterns observed across children and families reviewed.

- Deep understandings of contextual factors and working conditions affecting daily frontline practice in the agencies being reviewed.

- Quantitative patterns of child and family status and practice performance results, based on key measures.

- Noteworthy accomplishments and success stories.

- Emerging problems, issues, and challenges in current practice situations explained in local context.

- Monitoring reports revealing the degree to which important requirements are being met in daily frontline practice.

- Critical learning and input for next-step actions and for improving program design, practice, and working conditions.

In sum, QSR is a multi-faceted action research and advancement process for improvement of practice point performance by improving the practice model and strategies used while building capacities to improve the local conditions of practice so the local practitioners succeed more often with more children and families in reaching family independence, permanency for children, and safe and sustainable case closures for the service system.

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EXPECTATIONS OF QSR REVIEWERS

Persons using this protocol should have completed the classroom training program (12 hours). Reviewers should be using the protocol in a shadowing/lead/mentoring role. The new reviewer's early case analysis and ratings, feedback sessions with the FCM and/or FCM Supervisor, oral case presentations, and case stories should be coached by a qualified mentor.

To become qualified, reviewers will complete a 2 hour training session on mentoring future reviewers. Users of this protocol should remember the following points:

- The QSR Protocol is used to review the: (1) status of a focus child and parent/caregiver on key indicators; (2) recent progress made on applicable change indicators; and (3) adequacy of performance of essential service functions for that child and parent/caregiver. Each focus child served is a unique and valid point-in-time measurement of frontline practice performance in a local system of care.

- Reviewers are expected to use genuineness, empathy, respect and professionalism in applying case review methods using this protocol and in developing child status, recent progress, and practice performance findings. Conclusions should be based on objective evaluation of pertinent evidence gathered during the review.

- Reviewers should focus on results and reflect their honest and informed appraisals in their ratings and report summary. When a reviewer mentions a concern about a participant in the oral debriefing, that same problem should be reflected in the reviewer's ratings and noted in the written case story.

- Report any risks of harm or possible abuse/neglect to the appropriate PQI team leader. Once the FCM and/ or the FCM Supervisor has been informed of the risks or possible abuse/neglect, then the reviewers and PQI staff will report the information to the Regional Manager. If the child/youth is believed to be at imminent risk of harm, then information needs to be reported to the appropriate PQI staff **IMMEDIATELY**..

- If while reviewing the case record material and conducting the interviews, it is determined there is a need to interview an individual not on the review schedule, the reviewer should request that the interview be arranged. If possible, the FCM should arrange a telephone or face-to-face interview.

- Before beginning your interviews, read the participant's service plan(s); any psychological, psychiatric evaluations; court documents; and contact notes for the past 180 days. Make notes for yourself of any questions you have from your record review, and obtain the answers during your interviews from the relevant person(s). You may have questions that need to be answered by the FCM before you begin your interviews.

- The completed Roll-Up Sheet for the case assigned to the reviewer MUST be given to the appropriate PQI team member by 4:00 pm on the second day of the review so that the information can be used to input scores in the database.

RATING SCALES AND TIMEFRAMES

The QSR Protocol uses a 6-point rating scale as a "yard stick" for measuring the situation observed for each indicator. [See the two rating scale displays presented on the next page.] The general timeframes for rating indicators are: (1) for child/youth and parent/caregiver status indicators, the reviewer focuses on the past 30 days and (2) for system performance indicators, the reviewer focuses on the past 90 days. (3) for select system performance indicators the reviewer will also focus on the past 12 months in addition to the last 90 days. (4) For all CFSR questions the reviewer will focus on the last 90 days and the past 12 months. These time parameters will help reviewers clearly and consistently define conditions necessary for a particular rating value. Greater clarity in rating values increases inter-rater reliability. The general rating values to use are explained in the sections that follow. An exception to the general rules is found in the Stability indicator.

CHILD AND FAMILY INDICATOR RATINGS

Presented below are general definitions of the rating levels and time-frames applied for child and family status indicators. The general interpretations for these ratings are defined as follows:

- **Level 6 - Optimal and Enduring Status.** The child, parent, or caregiver status situation has been generally optimal [best attainable taking age and ability into account] with a consistent and enduring high quality pattern evident, without being less than good (level 5) at any point or any essential aspects. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally optimal and enduring, never dipping below level 5 at any moment. Confidence is high that long-term needs or outcomes will be or are being met in this area—perhaps reaching the level indicated for sustainable, safe case closure in this status area.

- **Level 5 - Good and Stable Status.** The child, parent, or caregiver status situation has been substantially and consistently good with indications of stability evident, without being less than fair (level 4) at any moment or in any essential aspect over that time period. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally good and stable, never dipping below level 4 at any moment. This status level is consistent with eventual satisfaction of major needs or attainment of long-term outcomes in the area.

QUALITY SERVICE REVIEW PROTOCOL RATING SCALE LOGIC

QSR Interpretative Guide for Child & Family Status Indicator Ratings

Maintenance Zone: 5-6

Status is favorable. Efforts should be made to maintain and build upon a positive situation.

6 = OPTIMAL STATUS. The best or most favorable status presently attainable for this person in this area [taking age and ability into account]. The person is doing great! Confidence is high that long-term needs or outcomes will be or are being met in this area in **achieving positive results**.
[A robust, enduring, and desired pattern]

5 = GOOD STATUS. Substantially and dependably positive status for the person in this area with an ongoing positive pattern. This status level is consistent with attainment of long-term needs or outcomes in area. Status is "looking good" and is likely to continue in **achieving positive results**.
[A recent and sustaining positive pattern]

Refine/Maintain Range: 4-6

Refinement Zone: 3-4

Status is fair or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = FAIR STATUS. Status is minimally or temporarily sufficient for the person to meet short-term needs or objectives in this area. Status has been no less than minimally adequate in **achieving positive results** at any time in the past 30 days, but may be short- term due to changing circumstances, requiring change soon. [1 month pattern]

3 = MARGINAL STATUS. Status is mixed, limited, or inconsistent and not quite sufficient to meet the person's short-term needs or objectives now in this area. Status in this area has been somewhat inadequate at points in time or in some aspects in **achieving positive results**. Any risks may be minimal.

Concerted Action Needed Range: 1-3

Improvement Zone: 1-2

Status is problematic or risky. Quick action should be taken to improve the situation.

2 = POOR STATUS. Status is now and may continue to be poor and unacceptable. The person may seem to be "stuck" or "lost" with status not improving. Any risks may be mild to serious.

1 = ADVERSE STATUS. The person's status in this area is poor and worsening. Any risks of harm, restriction, separation, disruption, regression, and/or other poor outcomes may be substantial and increasing.

QSR Interpretative Guide for Practice Performance Indicator Ratings

Maintenance Zone: 5-6

Performance is effective. Efforts should be made to maintain and enhance a positive practice situation.

6 = OPTIMAL PERFORMANCE. Excellent, consistent, effective practice for this person in this function area. This level of performance is indicative of exemplary practice and results for the person in achieving positive results. [A robust, enduring, effective pattern]

5 = GOOD PERFORMANCE. At this level, the system function is working dependably for this person, under changing conditions and over time. Effectiveness level is consistent with meeting long-term needs and goals for the person in achieving positive results. [A recent and sustaining positive pattern]

Refine/Maintain Range: 4-6

Refinement Zone: 3-4

Performance is fair or marginal and maybe changing. Further efforts are necessary to refine the practice situation.

4 = FAIR PERFORMANCE. This level of performance is minimally or temporarily sufficient to meet short-term need or objectives in **achieving positive results.** Performance may be time- limited, somewhat variable, or require adjustment soon due to changing circumstances.
[1 month continuing pattern. Some refinement may be indicated]

3 = MARGINAL PERFORMANCE. Practice at this level may be under-powered, inconsistent or not well-matched to need in achieving positive results. Performance is insufficient for the person to meet short-term needs or objectives.
[With refinement, this could become acceptable in the near future.]

Concerted Action Needed Range: 1-3

Improvement Zone: 1-2

Performance is inadequate. Quick action should be taken to improve practice now.

2 = POOR PERFORMANCE. Practice at this level is fragmented, inconsistent, lacking necessary intensity, or off-target. Elements of practice may be noted, but it is incomplete/not operative on a consistent basis.

1 = ADVERSE PERFORMANCE. Practice may be absent or not operative. performance may be missing (not done). - OR - Practice strategies, if occurring in this area, may be contra-indicated or may be performed inappropriately or harmfully.

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- **Level 4 - Fair Status.** The child, parent, or caregiver status situation has been at least minimally adequate at all times over the past 30 days, without being inadequate at any point or any essential aspect over that time. The situation may be dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed pattern may not endure or may have been less than minimally acceptable in the recent past, but not within the past 30 days.

- **Level 3 - Marginally Inadequate Status.** The child, parent, or caregiver status situation has been somewhat limited or inconsistent over the past 30 days, being inadequate at some moments in time or in some essential aspect(s) over this time period. The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have endured or may have been less than minimally acceptable in the recent past and somewhat inadequate.

- **Level 2 - Poor Status.** The child, parent, or caregiver status situation has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s). The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured or may have been inadequate and unacceptable in the recent past and substantially inadequate.

- **Level 1 – Absent, Adverse, or Worsening Status**. The child, parent, or caregiver status situation has been substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. The observed pattern may have endured or may have recently become unacceptable, substantially inadequate, and worsening.

SYSTEM PERFORMANCE INDICATOR RATINGS

The same general logic is applied to performance indicator rating levels as is used with the status indicators. The general interpretations for performance indicator ratings are defined as follows:

- **Level 6 - Optimal and Enduring Performance.** The practice/system performance situation observed for the child or parent has been generally optimal [best attainable given adequate resources] with a consistent and enduring pattern evident, without ever being less than good (level 5) at any point or in any essential aspect. The practice situation may have had brief moments of minor fluctuation, but performance in this area has remained generally optimal and stable. This excellent level of performance may be considered "best practice" for the system function, practice, or attribute being measured in the indicator and worthy of sharing with others.

- **Level 5 - Good and Stable Performance.** The practice/system performance situation observed for the child or parent has been substantially and consistently good with indications of stability evident, without being less than fair (level 4) at any moment or in any essential aspect. The situation may have had some moments of minor fluctuation, but performance in this area has remained generally good and stable. This level of performance may be considered "good practice or performance" that is noteworthy for affirmation and positive reinforcement.

- **Level 4 - Fair Performance**. The practice/system performance situation observed for the child or parent has been at least minimally adequate at all times over the past 30 days, without being inadequate (level 3 or lower) at any moment or in any essential aspect over that time period. The performance situation may be somewhat dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed performance pattern may not endure long term or may have been less than minimally acceptable in the recent past, but not within the past 30 days. This level of performance may be regarded as the lowest range of the acceptable performance spectrum that would have a reasonable prospect of helping achieve desired outcomes given that this performance level continues or improves. Some refinement efforts are indicated at this level of performance at this time.

- **Level 3 - Marginally Inadequate Performance.** The practice/system performance situation observed for the child or parent has been somewhat limited or inconsistent, being inadequate at some moments in time or in some essential aspect(s) over this time period. The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have been less than minimally acceptable (level 3 or lower) in the recent past and somewhat inadequate. This level of performance may be regarded as falling below the range of acceptable performance and would not have a reasonable prospect of helping achieve desired outcomes. Substantial refinement efforts are indicated at this time.

- **Level 2 - Poor Performance.** The practice/system performance situation observed for the child or parent has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s) recently. The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured for a while or may have become inadequate and unacceptable in the recent past and substantially inadequate. This level of inadequate performance warrants prompt attention and improvement.

- **Level 1 - Absent, Adverse, or Worsening Performance**. The system performance situation observed for the child or parent has been missing, inappropriately performed, and/or substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. This level of absent or adverse performance warrants immediate action or intervention to address the gravity of the situation.

ROLE AND RESPONSIBILITIES OF A QSR REVIEWER

The reviewer conducts an independent, competent, accurate, and fair appraisal of the quality and consistency of interceptive practices and services by applying the QSR Protocol to children and families selected for review. The qualified reviewer is someone who is trained on and competent in the use of the protocol and review process. The reviewer maintains an independent, objective attitude, proper demeanor, and utilizes strength-based language when conducting review work. A reviewer does not conduct a review for a child/family when the reviewer might have a personal bias (arising from personal relationships) or when there might be the appearance of such.

It is important that QSR findings, ratings, and recommendations be viewed as being impartial. The reviewer uses professional care by following the QSR process and using the protocol in the way that the protocol training has directed. It means that findings and conclusions are based on information gained from

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the QSR process and that the reviewer can explain and support with evidence what led to making certain determinations. It means focusing on results and yet being strengths-based in providing information (oral and written) to local staff.

SOME "DO'S" FOR QSR REVIEWERS

- Be prepared before conducting all QSR assignments.
- Be punctual for interview appointments and other scheduled activities.
- Be independent and objective in your inquiry and decision making when conducting review activities.
- Follow the protocol. Ask for assistance when necessary.
- Use gathered evidence to support ratings and conclusions.
- Report any safety concerns to the appropriate PQI team member.
- Be respectful of agency staff and key informants. Conduct all interviews face-to-face whenever possible.
- Protect the confidentiality of information when conducting interviews across a range of key informants.
- Be mindful that the reviewer role is limited to disciplined inquiry and reporting. This role does not involve direct intervention into the situations observed.
- Be a factual, balanced, and strength-based when reporting findings.
- Offer 1- 3 practical, manageable options for consideration by local staff rather than specific directions.

SOME "DON'TS" FOR QSR REVIEWERS

- Don't come unprepared, disorganized, or late to scheduled review activities. Poor preparation, organization, or tardiness casts doubt on reviewer credibility.
- Don't make up your mind about a provider before conducting the review. Recognize and avoid personal biases.
- Don't drift from the protocol or definitions used for rating.
- Don't offer personal perspectives, judgments, or opinions to persons encountered.
- Don't appear indifferent to concerns expressed by key informants.
- Don't share personal or confidential information about a child or family across respondents.
- Don't overwhelm local staff with too many suggestions.
- Don't do "TA or Training" during debriefing sessions.

ORGANIZATION OF THIS PROTOCOL BOOKLET

This protocol booklet is organized into the following sections:

- **Introduction**: This first section of the protocol provides a basic explanation of practice principles and concepts on which the QSR inquiry process is based, the review process, and protocol design.
- **Child Status Indicators**: The second section provides the child status indicators used in the review.
- **Parent/Caregiver Status Indicators**: The third section provides the parent/caregiver status indicators used in the review.
- **System Performance Indicators**: The fourth section provides the practice measurement indicators used in the review.
- **Overall Ratings**: The fifth section provides directions for determining the overall rating.
- **Reporting Outlines**: The sixth section provides outlines that reviewers use in developing and presenting the ten-minute oral summary of case findings and the written summary report.
- **Clarifications**: The seventh section provides clarification for scoring specific indicators in assessment cases. Additional information includes a glossary of acronyms.

SECTION 2

CHILD/YOUTH STATUS INDICATORS

CHILD/YOUTH STATUS REVIEW 1: SAFETY

SAFETY: To what degree: • Is the child/youth free of abuse, neglect, and exploitation by others in his/her place of residence and other daily settings? • Is the child/youth free from injury caused by others in his/her daily home, school, and community settings? • Do parents and caregivers provide the attention, actions, and supports necessary to protect the child/youth from known risks of harm in the home? [past 30 days]

Freedom from harm is a state of child well-being that exists in the balance of interactions between any known risks of harm and necessary protections put into place by parents and/or out-of-home caregivers, teachers, baby sitters, and others having immediate responsibility for the child. Thus, the capability and reliability of the parents (and other responsible persons) in recognizing risks of harm and protecting the child from those risks must be considered by reviewers. This consideration extends to the effectiveness of any protective strategies (e.g., no-contact orders, safety plans, after-school child supervision plans) put into place to keep a child free from known risks. This does not imply an absolute protection from all possible risks to life or physical well-being. The child should be free from known and manageable risks of harm in his/her daily settings. This means the child is free from abuse and neglect, including freedom from intimidation and unwarranted fears that may be intentionally induced by parents, caregivers, other children, or treatment staff for reasons of manipulation or control. The child should have food, shelter, and clothing adequate to meet basic physical needs as well as adequate care and supervision of parents/caregiver(s), as appropriate to the child's age and developmental needs. A child who is at risk of harm or who lives in fear of assault, exploitation, humiliation, hostility, isolation, or deprivation may be at risk of suicide, disability, mental illness, co-dependent behavior patterns, learning problems, low self-esteem, and perpetrating similar harm on others. Freedom from harm is an essential condition for child well-being and development.

Determine from Informants Observations Plans and Records

1. Is the child currently or has the child been a victim of abuse, neglect, or exploitation in the home or community?

2. Does the parent/caregiver present a pattern of abuse, neglect, or exploitation of the child? • How many reports have been made over the life of the case and/or in the past 18 months? • Were they substantiated? • What is the present status over the past 30 days?

3. Is the child fearful, intimidated, or at high risk of harm in any of his/her current daily settings and activities?

   - Family home (including unsupervised visitation in the family home prior to reunification)
   - Out-of-home living arrangement (e.g., foster home or group home)
   - School (including early intervention, Head Start, K-12 grade school, alternative education program, vocational training)
   - Work (including a work experience program, apprenticeship placement, part-time job, supported employment)
   - After school (e.g., an informal neighbor child-sitting arrangement or an after-school program at the Boys & Girls Club)
   - Weekend (including the use of a child's "free time" in and around the home while away from organized activities)
   - Play (including informal neighborhood play activities and organized youth activities such as sports, clubs, church activities)
   - Treatment for mental illness or addiction (including any setting in which seclusion or restraint may be used)
   - Detention (including locked detention)

   NOTE: *Child self-endangerment, as a risk of harm, is addressed in Indicator 2: Behavioral Risk*

4. Does the child have his or her immediate food, clothing, shelter, and medical/mental health needs met? • Are physical living conditions hazardous or threatening to the safety or well-being of the child? • Are the parent/caregiver's methods of discipline appropriate for this child?

5. Does the child receive an appropriate level of care and supervision from parents/caregivers and other adults, relative to age and special needs? Has a safety plan or Family Support/Community Service Plan been developed to ensure the child's safety?

6. Is the child's care or supervision situation currently compromised by the parent/caregivers pattern of violent behavior, abuse/addiction to drugs and/or alcohol, mental illness/emotional instability, criminal activity, developmental status, cognitive ability, or domestic violence?

7. What informal supports and resources is the family now using to keep the children free from harm? • What recent family changes are now in place that help the family to better recognize risks of harm and to protect the child in the home from those risks?

8. How reliable are any protective strategies (e.g., no-contact order, safety plan) used to keep the child and/or family free from harm?

9. Are parents/caregivers aware of any risks to the child? • How reliable are parents/caregiver(s) in recognizing risks of harm and taking steps to protect the child from those risks? • Are known risks being managed effectively for the child?

CHILD/YOUTH STATUS REVIEW 1: SAFETY

Description and Rating of the Focus Child/Youth's Current Status

NOTE: *Child self-endangerment, as a risk of harm, is addressed in Indicator 2: Behavioral Risk*

Description of the Status Situation Observed for the Child/Youth	Rating Level
♦ **Optimal Safety.** Findings show an **excellent situation** for the child. The child has a risk-free living situation at home with fully reliable and competent parents/caregiver(s) who protect the child well at all times. Any protective strategies used are fully operative and dependable in maintaining excellent conditions. The child is free from harm in other daily settings, including at school and in the community. At home and/or in other settings, the child is free from abuse, neglect, exploitation, and/or intimidation.	**6**
♦ **Good Safety.** Findings show a **good situation** for the child. The child has a generally risk free living situation at home with reliable and competent parents/caregiver(s) who protect the child well under usual daily conditions. Any protective strategies used are generally operative and dependable in maintaining acceptable conditions. The child is generally free from risk in other daily settings, including at school and in the community. At home and/or in other settings, the child is free from abuse, neglect, exploitation, and/or intimidation.	**5**
♦ **Fair Safety.** Findings show a **fair situation** in being free from imminent risk of abuse or neglect for the child. The child has a fairly safe living arrangement with the present parents/caregiver(s). Any protective strategies have been recognized and utilized in reducing risks of harm. The child is at least fairly free from serious risks in other daily settings including at school and in the community. At home and/or in other settings the child may have very limited exposure to intimidation.	**4**
♦ **Marginal Safety.** Situation indicates **somewhat inadequate protection** of the child from abuse or neglect which poses an elevated risk of harm for the child. Any protective strategies used may have been recognized but not utilized in reducing risks of harm. The child may be exposed to somewhat elevated risks of harm in his/her home and/or in other daily settings possibly at school and in the community. At home and/or in other settings the child may be exposed to occasional intimidation and fear of harm. Concerted action is needed in this area.	**3**
♦ **Poor Safety.** Situation indicates **substantial and continuing risks of harm** for the child. At home and/or in other daily settings the child may sometimes experience abuse neglect exploitation or intimidation. Any protective strategies used may not have been recognized or utilized in reducing risks of harm. The child may be exposed to substantially elevated risks of harm in his/her home and/or in other daily settings possibly at school and in the community. At home or in other settings the child may be exposed to frequent or serious intimidation and fears of harm. Concerted action is needed in this area.	**2**
♦ **High Safety Risk.** Situation indicates **serious and worsening risks or harm** for the child. A pattern of abuse neglect exploitation or intimidation by persons in the current daily life of the child may be undetected or unaddressed in the home and/or in other daily settings. Any protective strategies used may not be implemented or effective when used leaving the child at risk of continuing any worsening harm. The child may be exposed to continuing and increasingly serious intimidation abuse and/or neglect. Concerted action is needed in this area.	**1**

CHILD/YOUTH STATUS REVIEW 2: BEHAVIORAL RISK (AGE 3 AND OLDER)

BEHAVIORAL RISK: • To what degree is the child/youth consistently avoiding self-endangerment situations and refraining from using behaviors that may put him/herself or others at risk of harm? [past 30 days]

Throughout development, children learn to avoid behaviors that can put themselves or others at risk of harm. This includes following family, school, and community rules, values, norms, and laws. This indicator is concerned with lawful community behavior, engagement in socially appropriate activities, and avoidance of risky and illegal activities. Thus, **self-endangerment** and **posing risk of harm to others** are central concerns of this indicator.

The focus of this indicator is the choices and decisions and subsequent behaviors and activities that children/youth make as it relates to engaging in risky or potentially harmful activities. For younger children, some examples of potentially harmful activities could include: excessive lying or running away, leaving home/supervision for extended periods of time, aggressive biting or pulling hair, extreme tantrums, fighting to the extent of causing bodily harm, playing with fire, or cruelty to animals. For older youth, examples of potentially harmful activities include: excessive truancy, running away, excessive lying, stealing, affiliation with gangs, dangerous thrill-seeking activities, serious destruction of property, eating disorders, suicidal ideation, or self-mutilation, use of weapons, use of substances, or purposefully placing themselves in dangerous environments and situations. If the youth is already involved with the juvenile justice system, the focus should be considered on whether the youth is making progress by not repeating offenses and is engaging in more socially appropriate activities, following rules, societal norms, and laws.

NOTE: *Unique time scales are used in ratings for this indicator. Time scales for ratings 4 and 5 in this indicator differ from the usual rating time scales in that both ratings use a 3-month time window.*

Determine from Informants, Observations, Plans, and Records

1. Does the child/youth present a pattern of self-endangering behaviors or danger to others? • If so, what are these behaviors and how are these behaviors being managed to keep people protected from such behaviors?

2. Is this child/youth presently making decisions and/or choosing to participate in activities (including illegal gang activities) that would cause harm to him/herself or others? • Are the child's behaviors in the community likely to lead to arrest and/or youth detention or adult incarceration?

3. Does the child/youth have a history of making decisions and behaving responsibly and appropriately that results in avoiding behaviors that would cause harm to him/herself or others?

4. Does this child/youth regularly associate with peers known for engaging in illegal or high risk activities? • Does this child engage in any high risk behaviors, including running away, robbery, car theft, drug use/sale, having unprotected sex, or prostitution?

5. Is there a recorded history, through school guidance/disciplinary issues, arrest records, or mandatory community service records, of the child engaging in harmful, illegal, or very risky activities? • Is the child involved with the juvenile justice system?

6. If the child/youth is involved with the juvenile justice system, is he/she actively participating with the court's plans and avoiding reoffending? • How is the youth modifying daily activities and peer members to avoid reoffending and become a "good citizen"?

7. Has the child/youth made suicidal gestures, threatened suicide, or had a suicide attempt? • Does the child need/have a **safety plan**?

8. Does the child/youth cause harm to him/herself by biting, pulling hair, head-banging, having severe tantrums, self-mutilation, binging on alcohol, or inhaling toxic vapors to get high?

9. What behaviors does the child/youth present that may put him/herself or others at risk of harm? • Has any harm actually occurred within the past 30 days? If so, what happened? • Are steps being taken to prevent or reduce the probability of repeated injury?

10. Is the child/youth presently placed in a specialized treatment or detention setting? • Has seclusion or restraint been used within the past 90 days to prevent harm to self or others? • If so, how frequently has seclusion or restraint been used and for what reasons? • Has use of any emergency control techniques been reduced over the past 90 days? • Has 911 been called because of this child's behavior recently?

CHILD/YOUTH STATUS REVIEW 2: BEHAVIORAL RISK (AGE 3 AND OLDER)

Description and Rating of the Child/Youth's Current Status

ALTERNATIVE TIME SCALE USED ON THIS INDICATOR: *This indicator is designed to look retrospectively over the past 6 months for a rating of 6 and over the past 3 months for ratings 4 and 5. This variation in the time scale is used to provide a common 30-day opportunity window for the occurrence of risk behaviors to determine whether a recent troublesome pattern has been reduced and sustained (rating 5) or continuing to be gradually reduced (rating 4) over that time period. A 30-day period would be too short to discern a clear pattern of reduction if low risk behaviors continue to occur less and less frequently. This indicator is not applied to infants and toddlers or to young children under the age of 36 months.* ***Emotional development and behavioral functioning should be considered together when rating this indicator.***

Description of the Behavioral Risk Status Observed for the Child/Youth	Rating Level
♦ **Optimal Behavioral Risk Status.** The child/youth is optimally and consistently avoiding behaviors that cause harm to self, others, or the community. This child/youth may have no history, diagnosis, or behavior presentations that are consistent with behavioral risk and is continuing this pattern. Or, the child/youth may have had related history, diagnoses, or behavior presentations in the past but has not presented risk behaviors at any time over the **past 6 months**. Behavioral risk status is excellent.	6
♦ **Good Behavioral Risk Status.** The child/youth is generally and substantially avoiding behaviors that cause harm to self, others, or the community. This child/youth may have a very limited history, diagnosis, or behavior presentations that are not significant now. Or, the child/youth may have had significant history, diagnoses, or behavior presentations in the past but has not presented the risk behaviors at any time over the **past 3 months**. Behavioral risk status is good.	5
♦ **Fair Behavioral Risk Status.** The child/youth is usually avoiding behaviors that cause harm to self, others, or the community but rarely may present a behavior that has low or mild risk of harm. The child/youth may have had related history, diagnoses, or behavior presentations in the past but may have presented risk behaviors at a declining or much reduced level over the **past 3 months**. Behavioral risk status is adequate to fair.	4
♦ **Marginal Behavioral Risk Status.** The child/youth is somewhat avoiding behaviors that cause harm to self, others, or the community but occasionally may present a behavior that has low to moderate risk of harm. The child/youth may have had related history, diagnoses, or behavior presentations in the past but may have presented risk behaviors at a somewhat lower risk or reduced level of harm over the **past 30 days**. Behavioral risk status is somewhat limited or inconsistent and worrisome. Concerted action is needed in this area.	3
♦ **Poor Behavioral Risk Status.** The child/youth is presenting behaviors that may cause harm to self, others, or the community. These possibly frequent presentations of behavior could have a moderate to high risk of harm. The child/youth may have had related history, diagnoses, or behavior presentations in the past and may be presenting risk behaviors at a serious and continuing level of harm over the **past 30 days**. Behavioral risk status is poor and a potential for harm is present. Concerted action is needed in this area.	2
♦ **Serious and Worsening Behavioral Risk Status.** The child/youth is presenting a pattern of increasing and/or worsening behaviors that may cause harm to self, others, or the community. These increasingly frequent or severe presentations of behavior have a moderate to high risk of harm. The child/youth may have had related history, diagnoses, or behavior presentations in the past and may be presenting risk behaviors at a serious and worsening level of harm over the **past 30 days**. The potential for harm is substantial and increasing. Concerted action is needed in this area.	1
♦ **Not Applicable.** The child is under three years of age.	NA

CHILD/YOUTH STATUS REVIEW 3: STABILITY

STABILITY: To what degree are: • The child/youth's daily living, learning, and work arrangements stable and free from risk of disruption? • The child/youth's daily settings, routines, and relationships consistent? • Known risks being managed to achieve stability and reduce the probability of future disruption? [Timeframe: past 12 months and next 6 months]

[STABILITY = CONTINUITY & NORMAL LIFE-STAGE CHANGES • INSTABILITY = DISRUPTIVE CHANGES IN A CHILD'S LIFE]

Any change in a child's life may be disruptive of established relationships and the familiar comforts, rhythms, and routines of a normal, stable life. While change is a part of life, the focus in this review is placed on movements of the child that may prove highly disruptive of the child's relationships and routines. A home move is considered a disruption if it is a sudden movement made in response to safety threats in the home and lasts for more than three days, is made to a more restrictive setting, and/or results in the child residing in another home with different caregivers. The reason may be resource home placement problems, a sudden psychiatric episode, placement in residential treatment, or other similar situations in which the child does not return to the same home following treatment. A brief hospitalization for acute care is not a disruption, if the child returns to the same home following discharge. Additional disruptions could include a change in the Family Case Manager, service providers or moving from one custodial parent to another. An educational move is considered disruptive if the child changes school due to a home disruption or if the school placement is changed for any reason (other than grade-level transitions or provision of temporary specialized educational services) to a more restrictive educational setting. Repeated school suspensions or expulsion would be considered disruptive to a child's education. A normal age-related transition from elementary to middle or to high school is not a disruption.

Continuity in caring relationships and consistency of settings and routines are essential for a child's sense of identity, security, attachment, trust, and optimal social development. The stability of a child's life will influence his/her ability to solve problems, negotiate change, assume responsibilities, judge and take appropriate risks, form healthy relationships, work as a member of a group, and develop a "conscience." Many life skills, character traits, and habits grow out of enduring relationships the child has with key adults in his/her life. Building nurturing relationships depends on consistency of contact and continuity of relationships. For this reason, stability and continuity in the child's living arrangement and social support network is a foundation for normal child development. A child removed from his/her family home should be living in a safe and appropriate home. If, for reasons of child protection, psychiatric treatment, or juvenile justice services, this child/youth is in a temporary setting or unstable situation, then prompt and active measures should be taken to restore the child to a stable situation.

Determine from Informants, Observations, Plans, and Records

1. Is the child living in a permanent home? • If continued instability is present, is it caused by unresolved permanency issues? • Is a concurrent permanency plan in place to minimize further disruption if efforts to achieve permanency fail? • If so, what is the permanency plan?

2. Does the child have a history of instability of living arrangements? • How many out-of-home placements has this child had in the past 12 months? For what reasons? • Of the placement changes, how many have been planned? • How many have been made to unite the child with siblings/ relatives, move to a less restrictive level of care, or make progress toward the planned permanency outcome (e.g., reunification or TPR/adoption)?

3. Are probable causes for disruption of home, school, or work present?
   - Parent/caregiver's history of frequent moves
   - Change in adults living in the home
   - Behavioral problems and discipline issues between parent and child
   - Members of the household threatened by the child's behavior
   - Parent/caregiver's inability/unwillingness to provide appropriate level of care or supervision

NOTE: *Track disruptions over the past 12 months and predict disruptions over the next 6 months.*

4. Has the child had a change in living, learning, or working environments in the past year resulting from:
   - Removal from his/her home or from another out-of-home care setting for safety reasons?
   - Behavioral problems or emotional disorders?
   - Required out-of-home treatment for serious emotional disturbances?
   - Criminal involvement resulting in arrest, entry to custody, youth detention, or juvenile corrections?
   - Chronic health conditions requiring frequent or extended hospitalization?

5. Has this child ever run away from home, school, or placement? • If so, is this likely to reoccur within the next 6 months?

6. What steps are being taken, if necessary, to prevent future disruptions and/or to achieve stable living, learning, and working environments and settings for this child?

CHILD/YOUTH STATUS REVIEW 3: STABILITY

Description and Rating of the Child/Youth's Current Status

ALTERNATIVE TIME SCALE USED ON THIS INDICATOR: *This indicator looks retrospectively over the past 12 months and prospectively over the next 6 months to assess and project the relative stability of the child's home settings and relationships. This is the only QSR indicator that uses a prospective dimension. A 12-month "opportunity window"* ***(consistent with CFSR timeframes)*** *is used to track recent life disruptions for the focus child to establish any movement pattern over that time period that has occurred. Prognosis for future disruption in the next six months is based on the pattern observed over the past 12 months (an ongoing movement pattern may be likely to continue in the near future) and on future events that would have a high probability of causing a disruption.*

Description of the Status Situation Observed for the Child/Youth	Rating Level
♦ **Optimal Stability.** The child has **optimal stability** and enjoys positive and enduring relationships with parents/caregivers, key adult supporters, and peers. There is no history of instability **over the past 12 months**. Only age-appropriate changes are expected in school settings.	**6**
♦ **Good Stability.** The child has **substantial stability** with no more than one disruptive change over the **past 12 months with none in the past 6 months**. The child has established positive relationships with parents/primary caregivers, key adult supporters, and peers in those settings. **Only age-appropriate changes are expected within the next 6 month**s. Any known risks are now well-controlled.	**5**
♦ **Fair Stability.** The child has **adequately acceptable stability** with no more than **one disruption within the past 12 months and none in the past 3 months**. The child has established positive relationships with parents/primary caregivers, key adult supporters, and peers in those settings. Only age-appropriate school changes may be expected in the next 6 months. Future disruption (unplanned moves) appears unlikely (probability < 50%) **within the next 6 months.**	**4**
♦ **Marginal Stability.** The child has **inadequate stability** over the past 12 months with more than **one disruption** within the past 6 months and none in the past 30 days. The child may not feel secure in the living arrangement and disruptions may have resulted in changes of parents/primary caregivers, key adult supporters, and peers. Further disruptions may occur within the next 6 months (probability > 50%). Causes of disruption are known. Concerted action is needed in this area.	**3**
♦ **Poor Stability.** The child has **substantial and continuing problems of instability** with **multiple changes** within the past 12 months and in at least the past 30 days. The child may feel insecure and concerned about his/her situation. Multiple, dynamic factors are in play, creating a **"fluid pattern of uncertain conditions"** in the child's life, leading to ongoing instability. Intervention efforts to stabilize the situation may be limited or undermined by current system of care difficulties. Concerted action is needed in this area.	**2**
♦ **Adverse Stability**. The child has **serious and worsening problems of instability** with multiple changes within the past 12 months. The child's situation seems to be **"spiraling out of control."** The child may be in temporary containment and control situations (e.g., detention or crisis stabilization) or a runaway. There is no foreseeable next placement with levels of supports and services expressed by service staff or providers. The child may be expelled from school. Concerted action is needed in this area.	**1**

CHILD/YOUTH STATUS REVIEW 4: PERMANENCY

PERMANENCY: • Is the child/youth living with parents or out-of-home caregivers that the child, parents or out-of-home caregivers, and other stakeholders believe will sustain until the child reaches adulthood and continue onward to provide family connections and supports? • If not, are permanency efforts presently being implemented on a timely basis that will ensure that the child/youth soon will be enveloped in enduring relationships that provide a sense of family, stability, and belonging? [Consistent with requirements for sustainable, safe case closure (LTV)] [Past 30 days]

Every child is entitled to a safe, secure, appropriate, and permanent home. Permanency is achieved when the child is living successfully in a family situation that the child, parents or out-of-home caregivers, and other stakeholders believe will endure lifelong. Permanency, commonly identified with the meaning of "family" or "home," suggests not only a stable setting, but also stable out-of-home caregivers and peers, continuous supportive relationships, and a necessary level of parental/caregiver commitment and affection. Families and children are entitled to permanency in a timely manner. Ideally, a child removed from his/her family home should be living in a safe, appropriate, and permanent home within 12 months of removal with no more than a single interim placement. Evidence of permanency includes resolution of guardianship, adequate provision of necessary supports for the out-of-home caregiver, and the achievement of stability in the child's home and school settings. Thus, safety, stability, and adequate caregiver functioning are co-requisite conditions of permanency for a child or youth. **The case should have identifiable steps which will move the child to timely, achievable, legal permanency.** Other permanency strategies or concurrent plans should be implemented immediately when reunification is determined not to be possible. Such a determination should be made in a timely manner after appropriate intensive services and any planned reunification efforts have proven unsuccessful or inappropriate. Where appropriate, termination of parental rights and adoption should be accomplished expeditiously. Because of the nature of congregate settings, with frequent turnover of out-of-home caregivers, time-limited stays, ever-changing peers, conditional commitment, and unreliable personal caring relationships, placements in congregate settings are rarely judged to achieve an acceptable permanency rating. An exception to this would be if a child is still placed in a congregate setting at the time of review, but everyone is ready to move the child to a safe, appropriate, and permanent family setting and the team agrees that the current placement and plan will produce permanency.

Determine from Informants, Observations, Plans, and Records

1. Is the child living with parents or out-of-home caregivers the child, parents/caregivers, system partners, and informal supports believe will endure lifelong? Is there a concurrent plan in place for the child? Is the team working towards a primary plan and concurrent plan simultaneously?
   - Do the primary permanency and concurrent goals appear to have appropriate identifiable steps, given the circumstances? • What does the child say about permanency choices?
   - If this is an older youth, are they receiving independent living services that will allow them to live safely and to function successfully and independently following services.
   - If the youth is 17-19 years of age, within six months of system exit, and receiving independent living services, are basic living needs, necessary supports, and social connections in place to ensure a smooth and successful adjustment following the transition into adult life?
2. If the child is residing with a parent, adoptive parent, or permanent out-of-home caregiver, for the identified home of the child:
   - Are legal steps to achieve permanency completed? • How much progress is being made in meeting conditions necessary for sustainable, safe case closure?
   - Do they understand and commit to the responsibilities for rearing the child? • Is the family adapting to embrace the child as a new member?
   - Are they incorporating the child's family of origin, traditions, and culture into the new family's arrangements?
3. If the child does not live with permanent out-of-home caregivers yet and the permanency goal is reunification, are the parents and child successfully resolving concerns to get the child safely home?
   - Is the parent acquiring, demonstrating, and sustaining required behavioral changes necessary to parent the child?
   - Is there a clear permanency plan? • Is it being implemented?
   - Does the child, family, system partners, and informal supports support the permanency plan? • What does the child say about permanency choices?
4. If the child does not live with permanent out-of-home caregivers yet and the permanency goal is adoption or guardianship, is preparation for adoption/guardianship timely and appropriate?
   - Is an alternative family identified or being actively recruited and developed? • Do the child, family, system partners, and informal supports support the permanency plan?
   - Have relatives, current out-of-home caregivers, and past out-of-home caregivers been approached about providing permanency?
   - Is the child aware of and becoming prepared for adoption/guardianship? • What does the child say about permanency choices?
5. Is the scope and pace of achieving permanency consistent with ASFA timelines? • If there have been delays, have adjustments been made to better address permanency? • What are the necessary conditions for sustainable, safe case closure and what progress is being made in meeting these conditions?
6. Do family members, current out-of-home caregivers, the child, and the team have and know about a concurrent plan? • Are back-up steps being taken to ensure timely permanency for the child if the current plan is halted or fails?

CHILD/YOUTH STATUS REVIEW 4: PERMANENCY

Description and Rating of the Child/Youth's Current Status

****Permanency and Long-Term View should be considered together when rating this indicator.****

Description of the Status Situation Observed for the Child	Rating Level
♦ **Optimal Status.** Child has **optimal/certain permanence**. The child has achieved legal permanency and/or lives in a family setting about which the child, out-of-home caregivers, and all team members have evidence will endure lifelong. If the child lives at home with his/her parents, identified risks have been eliminated and stability has been sustained over time. A primary and concurrent goal has been developed and all team members are aware of the steps necessary to achieve each plan.	**6**
♦ **Good Status.** Child has **substantial/promising permanence**. The child lives in a family setting (his/her own or that of an out-of-home caregiver) that the child, out-of-home caregivers, team members, and informal supports have confidence will endure lifelong. A plan is implemented that supports that confidence because safety and stability have been achieved. If in a resource family, there is agreement that adoption/guardianship issues will be imminently resolved. For children old enough to make a responsible judgment, the child and out-of-home caregiver (in all cases) are committed to the plan. A primary and concurrent goal has been developed and most team members are aware of the steps necessary to achieve each plan.	**5**
♦ **Adequate to Fair Status.** Child has **adequately acceptable to fair permanence**. The child lives in a family setting that the child, out-of-home caregivers, caseworker, and core team members expect will endure until the child reaches maturity. They are successfully implementing a well-crafted plan that supports that expectation because safety and stability are being achieved. If in an adoptive family, adoption/guardianship issues are being resolved. **- OR -**The child is still living in a temporary placement, but the child, out-of-home caregivers, team members, and informal supports are ready to move the child to a safe, appropriate, and permanent family setting. Readiness for permanency is evident, because a realistic and achievable child and family plan is being implemented, a permanent home has been identified, and the transition is being planned. The team agrees that the prospective placement and plan will produce permanency, because the child is receiving what the child needs for implementing the actual permanency goal and the parents or future permanent out-of-home caregiver is becoming prepared for receiving the youth. For children old enough to make a responsible judgment, the child and out-of-home caregiver (in all cases) are committed to the plan. A primary and concurrent goal has been developed and some team members are aware of the steps necessary to achieve this plan.	**4**
♦ **Marginal Status.** Child has **somewhat inadequate/uncertain permanence**. The child lives in a home that the child, out-of-home caregivers, team members, and informal supports are hopeful could endure lifelong, and they are working on crafting a plan that supports that hope by attempting to achieve safety and stability. **- OR -**The child is living on a temporary basis with an out-of-home caregiver, but likelihood of reunification or finding another permanent home remains uncertain. If in an adoptive family, adoption/guardianship issues are being assessed. Any concurrent pathways used may be somewhat slower or more troublesome than foreseen. For children old enough to make a responsible judgment, the child and out-of-home caregiver (in all cases) may be considering the plan. A concurrent goal is known by some team members but most team members are not aware of the steps necessary to achieve the plan. Concerted action is needed in this area.	**3**
♦ **Poor Status.** Child has **substantial and continuing problems of unresolved permanence**. The child is living in a home that the child, out-of-home caregivers, team members, and informal supports doubt could endure until the child becomes independent, due to safety and stability problems or failure to resolve adoption/guardianship issues, or because the current home is unacceptable to the child. **- OR -** The child remains living on a temporary basis with an out-of-home caregiver without a clear, realistic, or achievable permanency plan being implemented. Any concurrent pathways used may have stalled or failed. A concurrent goal is known by a few team members but the team members are not aware of the steps necessary to achieve the plan. Concerted action is needed in this area.	**2**
♦ **Adverse Status.** Child has **serious and worsening problems of unresolved permanence**. The child is moving from home to home due to safety and stability problems or failure to resolve adoption/guardianship issues, or because the current home is unacceptable to the child. **- OR -** The child remains living on a temporary basis with an out-of-home caregiver without a clear, realistic, or achievable permanency plan being implemented. A concurrent goal has not been developed and team members are not aware of the steps necessary to achieve the plan. Concerted action is needed in this area.	**1**

CHILD/YOUTH STATUS REVIEW 5: APPROPRIATE LIVING ARRANGEMENT

LIVING ARRANGEMENT: To what degree: • Is the child/youth in the most appropriate/least restrictive living arrangement, consistent with needs for family relationships, social connections, age, ability, special needs, education, and positive peer group affiliation? • If the child is in temporary out-of-home care, does the living arrangement meet the child's needs to be connected to his or her language and culture, community, faith, extended family, tribe, social activities, and peer group? [past 30 days]

NOTE: *This indicator applies to the child's current living situation, where the child or youth will sleep tonight.*

The child's home is the one that the child has lived in for an extended period of time. For children who are not in out-of-home care, this home can be with the parents, relatives (informally arranged by family), adoptive parents, or a guardian. For children in out-of-home care, the living arrangement can be in family foster care, therapeutic foster care, group home, or residential treatment. The child's home community is generally the area in which the child has lived for a considerable amount of time and is usually the area in which the child was living prior to removal. A child's home community is the least restrictive, most appropriate, inclusive setting in which the child spends his/her time on a daily basis. The community is a basis for a child's identity, culture, sense of belonging, and connections with persons and things that provide meaning and purpose for the child. Whenever safe, the child should remain in the home with his/her family. If the child must be temporarily removed from the home, the child should live, whenever possible, with siblings and relatives or in his/her home community. Children under the age of six should never be placed in congregate care (i.e., group homes, shelter care, and child-care institutions). Some children with special needs may require temporary services in therapeutic settings, which must be the least restrictive, most appropriate, and inclusive living arrangement necessary to meet the child's needs and circumstances.

Determine from Informants, Observations, Plans, and Records

1. Is the child living in his or her family home? • If not, does the child's current living arrangement facilitate the child's connections to his or her culture, community, faith, extended family, and social relationships? • Are these connections meaningful to the child?

   - Is the child's home an appropriate environment for the child?
   - Are the parents (or other out-of-home caregivers) able to meet the child's daily needs for care and nurturing?
   - Does the child have any special needs (medical, behavioral, cognitive, etc.)? • If so, does the parent have the capacity and supports necessary to address the special needs?

2. If the child is in a temporary out-of-home living arrangement, the following points should be considered in determining the appropriateness of the setting: [Consider the appropriateness of the living arrangement with ICWA, MEPA, and ASFA, as applicable to the child.]

   - Is the child living in his/her home community (neighborhood and community close to friends, in his/her school district, and where he/she can continue extracurricular activities)? • Is this home consistent with the child's language and culture?
   - Does the placement provide appropriate continuity in connection to home, school, faith-based organization, peer group, extended family, and culture?
   - Is the child placed with the non-custodial parent or relatives? • If not, are there clear reasons why not?
   - Is the child placed with siblings? • If not, are there clear reasons as to why this was not appropriate based upon the needs of the child?
   - Is the placement conducive to maintaining family connections and does the out-of-home caregiver support these activities?
   - Does the child feel safe and well cared for in this setting?
   - Should reunification not be possible, would the out-of-home caregiver be able and willing to provide for permanency? • Is this home consistent with ICWA?
   - Is the living arrangement able to meet the child's developmental, emotional, behavioral, and physical needs and does it provide for appropriate levels of supervision and supports?
   - Does the out-of-home caregivers encourage the child to participate in activities that are appropriate to his/her age and abilities (sports, creative activities, etc.) and support socialization needs with peers and others?

3. If the child is living in a group care (more than five children) or residential treatment center, the reviewer should consider the following items.

   - Does the child feel safe and well cared for in this setting?
   - Is this the less restrictive and most inclusive setting that is able to meet the child's needs?
   - Is the child placed with children in his/her same age group?
   - Does the placement provide for the appropriate level of supervision, supports, and therapeutic services?
   - Does the placement provide for family connections and linkages to the home community?

4. Does the child, parents, out-of-home caregivers, therapists, and FCM believe that this is the best place for the child to be living?

CHILD/YOUTH STATUS REVIEW 5: APPROPRIATE LIVING ARRANGEMENT

Description and Rating of the Child/Youth's Current Status

NOTE: *This indicator applies to the child's current living situation, where the child or youth will sleep tonight.*

Description of the Status Situation Observed for the Child	Rating Level

- **Optimal Living Arrangement. The child is living in the most appropriate setting to address his/her needs.** The living arrangement is optimal to maintain family connections, including the child's relationship with the siblings and extended family members. The setting is able to entirely provide for the child's needs for emotional support, educational needs, family relationships, supervision, and socialization and addresses special and other basic needs. The setting is optimal for the child's age, ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential treatment center, the child is in the least restrictive environment necessary to address his/her needs. **6**

- **Good Living Arrangement. The child is living in a setting that substantially meets his/her needs.** The living arrangement substantially provides the condition to maintain family connections, including the relationships with the siblings and extended family members. The setting provides the necessary educational needs, family relationships, supervision, supports, and services to provide substantially for the child's emotional, social, special, and other basic needs. The setting is substantially consistent with the child's age, ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential treatment center, the child is in the least restrictive environment necessary to address his/ her needs. **5**

- **Fair Living Arrangement. The child is living in a setting that is adequately consistent with his/her needs.** The living arrangement adequately provides the conditions necessary to maintain family connections, including the relationship with the siblings and extended family members. The setting adequately provides the necessary educational needs, family relationships, supervision, supports, and services to address the child's emotional, social, special, and other basic needs. The setting is adequately consistent with the child's age ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential treatment center, the child is in the least restrictive environment necessary to address his/her needs. **4**

- **Marginal Living Arrangement. The child is living in a setting that only partially addresses his/her needs.** The living arrangement is partially inconsistent with the conditions necessary to maintain family connections, including relationships with the siblings and extended family members. The setting only partially provides for the necessary educational needs, family relationships, supervision, supports, and services to address the child's emotional, social, special, and other basic needs. The setting is partially consistent with the child's age, ability, culture, language, and faith-based practices. If the child is in a group home or residential treatment center, the child is not in the least restrictive setting. The level of care or degree of restrictiveness may be slightly higher or lower than necessary to address the child's needs. Concerted action is needed in this area. **3**

- **Poor Living Arrangement. The child is living in a substantially inadequate home or setting.** The living arrangement inadequately addresses conditions necessary to maintain family connections. The necessary level of educational needs, family relationships, supervision, supports, and services to address the child's needs are inadequate. The setting is inconsistent with the child's age, ability, culture, language, and faith-based practices. If the child is in a group home or residential treatment center, the setting is not least restrictive. The level of care or degree of restrictiveness is substantially more or less than necessary to meet the child's needs. Concerted action is needed in this area. **2**

- **Adverse Living Arrangement. The child is living in an inappropriate home or setting for his/her needs**. The living arrangement does not provide for family and community connections. The necessary level of educational needs, family relationships, supervision, supports, and services to address the child's needs is absent. If the child is in a group home, detention facility, or residential treatment center, the environment is much more restrictive than is necessary to meet the child's needs while protecting others from the child/youth's behavioral risks. Or, the child or youth may be on runaway status, homeless, residing in a homeless shelter, or in temporary shelter care for more than 30 days. Concerted action is needed in this area. **1**

CHILD/YOUTH STATUS REVIEW 6: PHYSICAL HEALTH

PHYSICAL HEALTH STATUS: To what degree: • Is the child/youth achieving and maintaining his/her optimum health status? • If the child/youth has a serious or chronic physical illness, is the child/youth achieving his/her best attainable health status given the disease diagnosis and prognosis? [past 30 days]

Children should achieve and maintain their best attainable health status, consistent with their general physical condition when taking medical diagnoses, prognoses, and history into account. Healthy development requires that the child's basic needs for proper nutrition, clothing, shelter, and hygiene be met on a daily basis. Proper medical and dental care (preventive, acute, and chronic) is necessary for maintaining good health. Preventive health care should include periodic examinations, immunizations, dental hygiene, and screening for possible developmental or physical problems. This extends to reproductive health care education and services for youth to prepare and protect them from making poor life choices, exposure to sexually transmitted diseases, and teen pregnancy.

Children prescribed medications on a continuous basis should be carefully monitored. A responsible adult should assure that the medications are taken as prescribed, that the effects of the medications (including side effects) are monitored, and that there is a mechanism to provide feedback with the physician on a regular basis. For children who are developmentally capable, the child should understand his/her condition, how to self-manage issues associated with the condition, the purpose of his/her medication, how to manage or report side effects of the medication, and how to self-administer their medication. If the child requires any type of adaptive equipment or other special procedures, persons working with the child are provided instruction in the use of the equipment and special procedures. Should a child have a serious condition, possibly degenerative, the services and supports have been provided to allow the child to remain in the best attainable physical status given his/her diagnoses and prognoses.

Determine from Informants, Observations, Plans, and Records

1. Are the child's basic physical needs being met adequately on a daily basis? • (If NOT, this may an indication of NEGLECT, a failure to provide critical care to the child. *(See Indicator 1: Safety.)*

    - Food, adequate nutrition, sleep, and daily exercise at a level necessary to balance the child's height and weight within a healthy range?
    - Sanitary housing that is free of safety hazards?
    - Daily care such as hygiene, dental care, grooming, and clean clothing?

2. Is the child achieving his/her optimal or best attainable health status?

    - Are the child's immunizations complete and up to date?
    - Does the child miss school due to illness more than would be expected?
    - Does the child have any recurrent health problems such as infections, sexually transmitted disease, colds, or injuries?
    - Does the child have recurrent health complaints, and if so, are they addressed (including dental, eye sight, hearing, etc.)?
    - Does the child appear to be underweight or overweight, and if so, has this been investigated?
    - Does the child use illegal substances?
    - If the child has had a need for acute care services, were they provided appropriately?

3. Has the child maintained his/her best attainable health status, given any physical health diagnoses?

4. If the child takes medication for health maintenance on a long-term basis, is the medication properly managed for the child's benefit?

    - A responsible adult should be monitoring the use of the medication, ensuring that it is taken properly, watching for signs of effectiveness or side effects, providing feedback to the physician, and making changes as warranted.
    - The child, at the level that she/he is capable, has been taught about his/her condition, understands how to self-manage the condition, understands the purpose and impact of the medication, and is able to self-administer his/her medication with supervision.

5. *OPTIONAL CONSIDERATION*: If the child is in out-of-home care, does she/he have access to sex education and family planning services based upon the child's age and developmental level (e.g., patient education, counseling, safe and effective contractive methods, medical exams, and school-based health services)?

CHILD/YOUTH STATUS REVIEW 6: PHYSICAL HEALTH

Description and Rating of the Child/Youth's Current Status

Description of the Status Situation Observed for the Child	Rating Level
♦ **Optimal Health Status.** Child is demonstrating excellent health, or if he/she has a chronic condition, is attaining the best possible health status that can be expected given the health condition. The child's growth and weight are well within age-appropriate expectations. Any previous or current health concerns have been met without any adverse or lasting impact, or there is no significant health history. Nutrition, exercise, sleep, and hygiene needs are fully met. This child appears to be in excellent physical health. If the child is in out-of-home care, she/he has access to sex education and family planning services based upon the child's age and developmental level.	6
♦ **Good Health Status**. Child is demonstrating a good, steady health pattern, considering any chronic conditions. The child's growth and weight are generally consistent with age-appropriate expectations. Any previous or current health concerns have been met in which there may be no lasting impact, or there is no significant health history for this child or youth. Nutrition, exercise, sleep, and hygiene needs are being substantially met. This child appears to be in good physical health. If the child is in out-of-home care, she/he has access to sex education and family planning services based upon the child's age and developmental level.	5
♦ **Fair Health Status.** Child is demonstrating an adequate to fair level of health status, considering any chronic conditions. The child or youth's physical health is somewhat close to normal limits for age, growth, and weight range. If existing, any previous or current health concerns are not adversely affecting functioning. Nutrition, exercise, sleep, and hygiene needs are usually being met. The child appears to be in fair physical health. If the child is in out-of-home care, she/he has access to sex education and family planning services based upon the child's age and developmental level.	4
♦ **Marginal Health Status.** Child is demonstrating a limited, inconsistent, or somewhat inadequate level of health status. Any chronic condition may be becoming more problematic than necessary. The child or youth's physical health is outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be adversely affecting functioning. Nutrition, exercise, sleep, and hygiene needs may be inconsistently met. The child appears to be in marginal, or mixed, physical health. Concerted action is needed in this area. If the child is in out-of-home care, she/he does not have access to sex education and family planning services based upon the child's age and developmental level.	3
♦ **Poor Health Status.** Child is demonstrating a consistently poor level of health status. Any chronic condition may be becoming more uncontrolled, possibly with presentation of acute episodes. The child or youth's physical health is significantly outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be significantly affecting functioning. Nutrition, exercise, sleep, and hygiene needs may not be being met, with significant impact on functioning. The child appears to be in poor physical health and physical health is not improving, rather, is remaining status quo. Concerted action is needed in this area. If the child is in out-of-home care, she/he does not have access to sex education and family planning services based upon the child's age and developmental level.	2
♦ **Worsening Health Status.** Child is demonstrating a poor or worsening level of health status. Any chronic condition may be increasingly uncontrolled, with presentation of acute episodes that increase health care risks. The child or youth's physical health is profoundly outside normal limits for age, growth, and weight ranges. If existing, any previous or current health conditions may be profoundly affecting functioning. Nutrition, exercise, sleep, and hygiene needs may not be being met, with profound impact. The child appears to be in poor physical health and his/her health status is declining. Concerted action is needed in this area. If the child is in out-of-home care, she/he does not have access to sex education and family planning services based upon the child's age and developmental level.	1

CHILD/YOUTH STATUS REVIEW 7: EMOTIONAL STATUS (AGE 3 AND OLDER)

EMOTIONAL STATUS: To what degree: • Is the child/youth presenting age-appropriate emotional development, adjustment, attachment, coping skills, and self-control? • Is the child/youth achieving and maintaining an adequate level of behavioral functioning in daily settings and activities, consistent with age and ability? [past 30 days]

Emotional development, life adjustments, appropriate coping skills, and self-management are essential to adequate daily functioning in a child's life. Well-being begins with having a sense of person, purpose, personal worth, and emotional connections. From birth through adolescence, the child learns to respond, enjoy, and cope with his/her relationships and environment. Children who develop resiliency obtain the ability to address their day-to-day challenges with a sense of self-efficacy. The very young child develops strong attachments and is able to engage in reciprocal interactions with others. As the child matures, he/she learns how to play cooperatively, uses language to express emotion, and begins to self-regulate emotions. The older child/adolescent develops the ability to experience the full range of emotions within normal limits of intensity and durations. The child/youth enjoys his/ her interactions with peers and has close friendships and meaningful relationships with adults. The child/youth is able to give and receive affection in an appropriate manner and understands the limits/boundaries associated with healthy relationships. The child learns to cope with ongoing and various stresses of life in a socially acceptable manner. Emotional well-being for a child or youth:

- Has a feeling of personal worth, a sense of belonging, and attachment to family and friends as well as affiliation with age-appropriate social groups.
- Is able to give and accept nurturing friendships and affection within safe and appropriate boundaries of social behavior.
- Is realistically aware of one's positive attributes, accomplishments, and potentialities, as well as areas that may be limitations.
- Is learning to self-regulate, delay gratification, and use age-appropriate levels of self-direction and control in daily activities and relationships.
- Recovers quickly from being upset and is able to handle frustration.
- Has a sense that he/she can manage his/her problems and handle issues effectively.
- Has internalized values, norms, and rules in a way that will help with appropriate growth.
- Can deal with ambiguity and conflicting viewpoints without over-reaction or presentation of self-isolating behaviors.
- Is able to positively identify with adults as appropriate role models and appropriately seeks assistance from adults.

NOTE: *This indicator does not apply to children under 3 years of age.*

Behavioral functioning addresses the manner in which the child interacts with others and his/her environment on a current daily basis. The child/ youth must handle the daily life events without becoming disruptive or displaying behaviors that interfere with his/her ability to fulfill his/her expectations and responsibilities. Children/youth's behavior can range from superior handling of issues with very few negative interactions to having very serious problems managing him/herself in multiple settings. If the child has been diagnosed with an emotional disturbance, the child may be functioning in a range that prohibits completion of many daily activities. For a child/youth, behavioral functioning means that he/she:

- Does not participate in disruptive behaviors in the home, school, or community. This involves active self-regulation and impulse control in school/ social activities.
- Is free of any behaviors that would interfere in his/her performance of the age-appropriate daily tasks and expectations.
- Demonstrates good judgment regarding age-appropriate activities of childhood or adolescence that he/she chooses to be involved in.
- Uses time in a constructive manner, consistent with academic or social norms, expectations, and rules at home, at school, and in the community.
- Is able to articulate his/her own wants and needs and is able to take meaningful steps to address those issues.
- If the child has been diagnosed with an emotional disturbance, the child is learning how to self-manage his/her behaviors and is using the necessary skills to function well in the school, home, and community on a daily basis.

Determine from Informants, Observations, Plans, and Records

1. What is this child's level of emotional development and life adjustment? • Is it consistent with the child's age and ability? • As appropriate to age and ability, does the child report having a sense of identity, personal worth, purpose in life, and acceptance by and affiliation with others?

2. How is the child adjusting to change and to any adverse life circumstances causing stress in his/her life? • Is the child currently presenting emotional or behavioral problems at school, at home, and in the community? • If so, has the child received a recent behavioral health assessment?

3. Does the child have a diagnosed psychiatric disorder using the DSM? • If so, has the child received education about this diagnosis and how to better manage related signs and symptoms? Is treatment resulting in symptom reduction and improved functioning?

4. If the youth uses medications for emotional/behavior problems, does the youth self-administer? • Are medications effective? • Are these medications monitored for safety and effectiveness at least quarterly? • Have any adverse side effects of medications been reported to the physician?

5. Is the child demonstrating personal responsibility for daily interactions, habits, and attitudes as appropriate to his/her age and ability? [Communicates thoughts and feelings in acceptable ways, abstains from behaviors that cause harm and/or are illegal]?

6. If the child presents serious risk factors (including illegal activities), are these risks recognized and acted upon? • How are risks being managed?

7. How has the child's emotional development and daily functioning changed over the past six months? • What is better today? • What is not? • Why?

CHILD/YOUTH STATUS REVIEW 7: EMOTIONAL STATUS (AGE 3 AND OLDER)

Scale for Rating the Child/Youth's Emotional Status

EMOTIONAL STATUS: To what degree is the child demonstrating his/her best attainable level of emotional development (e.g., life adjustment, coping, hopefulness, self-direction, self-regulation, delayed gratification; sense of personal worth, attachment, affiliation, resilience) and daily behavioral functioning in normal activities, taking into account the child's age, trauma history, psychiatric or substance use history, or diagnoses/prognoses, (e.g., mental retardation, autism, developmental trauma disorder or post-traumatic stress disorder, bi-polar disorder) presented by the child? ***Emotional development and behavioral functioning should be considered together when rating this indicator.*** *Self-endangerment and risk to others are addressed in Indicator 2. Apply this indicator to children and youth above the age of three years.*

Description of the Status Situation Observed for the Child	Rating Level
♦ **Optimal Emotional Status**. Consistent with age and ability, the child is demonstrating excellent emotional development in all key areas of social/emotional development and life adjustment. Child may be demonstrating excellent daily functioning. The child may show excellent behavioral status in all key life areas.	6
♦ **Good Emotional Status**. Consistent with age and ability, the child is demonstrating a good and substantial level of emotional development in most areas of social/emotional development and life adjustment. The child may be demonstrating a good, steady level of daily behavioral functioning in most key functional life areas.	5
♦ **Fair Emotional Status.** Consistent with age/ability, the child is demonstrating a temporarily adequate level of emotional development. The child may be having problems adjusting in one area and is showing signs of distress in one area of emotional responsiveness or adaptations. The child's emotional development is adequately acceptable. The child may be demonstrating a temporarily adequate to fair level of daily behavioral functioning. The child may be functioning fairly well in his/her home and environment but may be having problems in one area of daily functioning. The child may have some disruptive behaviors or internalizing behaviors that are under adequate control or may be showing rare, minor problems. The child's behavioral functioning is at least minimally satisfactory to fair at the moment, but may be at some risk of decline.	4
♦ **Marginal Emotional Status.** Consistent with age and ability, the child is demonstrating a limited or inconsistent level of emotional development. The child may be having adjustment problems in several areas. The child may be showing distress in several areas of emotional responsiveness or adaptations. The child may be demonstrating a limited or inconsistent level of behavioral functioning in daily settings. The child is showing some emerging or continuing behavioral problems in the home, school, or community and may be exhibiting behaviors that interfere with several areas of daily functioning. The child may not be responding well to attempts to address disruptive behaviors or internalizing behaviors. Concerted action is needed in this area.	3
♦ **Poor Emotional Status.** Consistent with age and ability, the child is demonstrating a consistently poor level of emotional development. The child may show no progress or improvement in areas of social/emotional development and life adjustment. Child is demonstrating a consistently poor level of behavioral functioning in daily settings and may show no progress or improvement in functional status. Concerted action is needed in this area.	2
♦ **Worsening Emotional Status.** Consistent with age and ability, the child is demonstrating a poor and worsening level of emotional development. Rather than meeting adjustment expectations, the child's social/emotional development may be regressing. Child is demonstrating a poor and worsening level of behavioral functioning in daily settings and activities. The child's functional behavioral status may be declining. Concerted action is needed in this area.	1
♦ **Not Applicable.** The child is under age three years.	NA

CHILD/YOUTH STATUS REVIEW 8A: EARLY LEARNING & DEVELOPMENT (UNDER AGE 5)

EARLY LEARNING: To what degree: • Is the young child's developmental status commensurate with his/her age and developmental capacities? • Is the child's developmental status in key domains consistent with age-appropriate expectations? [past 30 days]

From birth, children progress through a series of stages of learning and development. The growth during this period is greater than any subsequent developmental stage. This offers great potential for accomplishments, but also creates vulnerabilities for the child if the child's physical status, relationships, and environments do not support appropriate learning, development, and growth. These developmental years provide the foundation for later abilities and accomplishments. Significant differences in children's abilities are associated with social and economic circumstances that may be impacting learning and development. The cumulative impact of multiple risk factors on development is well documented. Examples of risk factors are: having a parent who abuses substances, exposure to violence and trauma, inappropriate child care and nurturing, and living in a dangerous environment or community. Children served by child welfare systems are at a very high risk for developmental delays and they often represent over 50% of the children under age five served through child welfare. Since this developmental period is critical to the child's future social, emotional, and cognitive development, every attempt should be made to provide these children with early intervention services both within the home and in child care settings. (Please see Indicators of Typical Developmental Ages 1-3 Years included in the packet).

NOTE: *An exception to this indicator would be a five or six year-old who is not yet enrolled in an educational program.*

Determine from Informants, Observations, Plans, and Records

1. Consistent with CAPTA, if this child is in the first 36 months of life, has this child been referred to screening for developmental delay or disability so that any indicated early intervention services can be provided to maximize the child's potential for growth and development?

2. If the child has had a developmental screening or assessment, have any developmental delays or disabling conditions been identified or diagnosed?

    - If so, to what degree and in what area?

3. Does the child appear to be achieving the key development milestones at or above age-appropriate levels?

    - Social/emotional development
    - Cognitive development
    - Physical/motor development
    - Language development
    - Self-care skills
    - School readiness skills

4. Does the child actively participate in self-care, play, socialization, and cognitive activities that appear within the appropriate range of development?

    - If not, has the child been screened and evaluated for developmental delays or disabilities? • If so, what are the significant findings regarding the child's development path, pace, and potential?

5. If the child presents developmental delays or disabilities, is the child receiving early interventional services provided via an Individualized Family Support Plan (IFSP) if under 36 months of age or an Individual Educational Plan (IEP) if between the ages of 36 and 60 months? • If not, why not?

6. If early intervention services are provided, do the child and parents seem to be responding to the interventions as shown in such areas as improved interaction, acceptance of attempts to nurture, more spontaneous play, emergence of language, etc.?

CHILD/YOUTH STATUS REVIEW 8A: EARLY LEARNING & DEVELOPMENT (UNDER AGE 5)

Description and Rating of the Child's Current Status

NOTE: *An exception to this indicator would be a five or six year-old who is not yet enrolled in an educational program.*

Description of the Status Situation Observed for the Child, under age 5 years	Rating Level
♦ **Optimal Developmental Status.** The child's current developmental status is at or above age expectations in all domains, based upon normal developmental milestones.	6
♦ **Good Developmental Status.** The child's current developmental status is at age expectations in all domains, however, there may be one or two areas in which the child is not as strong and merits ongoing careful monitoring.	5
♦ **Fair Developmental Status.** The child's current developmental status is near age expectations in most of the major domains and may be slightly below expectations in a few areas. If the child and caregiver is participating in early intervention programs either at home or in a child care environment, the child is making substantial gains and appears to be approaching age-appropriate expectations.	4
♦ **Marginal Developmental Status.** The child's developmental status is mixed, somewhat near expectations in some domains, but showing significant delays in others. If the child and caregiver is participating in an early intervention program either at home or in a child care program, the child is making moderate to slow developmental gains and may not be improving in some domains. Concerted action is needed in this area.	3
♦ **Poor Developmental Status.** The child's developmental status is showing significant delays in several areas as compared to age-appropriate expectations. If the child and caregiver are involved in an early intervention program, either at home or in a child care program, the child may be making gains but has such significant delays that it is not likely that the child will reach age-appropriate levels of functioning for some time. Concerted action is needed in this area.	2
♦ **Adverse Developmental Status.** The child's current developmental status is far below developmental milestones and there may be a decline in certain domains. The child and caregiver may be involved in early intervention programs, but the rate of improvement is minimal. Concerted action is needed in this area.	1
♦ **Not Applicable.** The child is over the age of 5 or has been enrolled in a formal educational setting.	NA

CHILD/YOUTH STATUS REVIEW 8B: LEARNING & DEVELOPMENT (AGE 5 AND OLDER)

LEARNING STATUS: Is the child/youth [according to age and ability]: (1) regularly attending school, (2) in a grade level consistent with age, (3) actively engaged in instructional activities, (4) reading at grade level or IEP expectation, and (5) meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent? [Past 30 days]

The child is expected to be actively engaged in developmental, educational, and/or vocational processes that are enabling the child to build skills and functional capabilities at a rate and level consistent with his/her age and abilities. This means that the child should be:

- Enrolled in an educational program, consistent with age and ability.
- Attending school regularly and at a frequency necessary to benefit from instruction and meet requirements for grade promotion, course completion, and entry into the next school or vocational program.
- Receiving instruction at a grade level consistent with the child's age [or ability, if the child is cognitively impaired].
- Reading at grade level, except when the child's instructional expectations and placement are altered via an IEP to an alternative curriculum. When an IEP is directing the child's education via placement in an alternative curriculum, specialized instruction, and related services, the child should be performing at the level anticipated in the IEP.
- Actively and consistently participating in the instructional processes and activities necessary to acquire expected skills and competencies.
- Meeting requirements for grade-level promotion, completing courses and assessment requirements and, where indicated in an IEP, fulfilling transition processes and requirements for making a smooth transition to the next school or vocational program.

This status review focuses on the child's current learning and academic status relative to access to, participation in, and fulfillment of basic educational requirements for entry into the next school or vocational program.

NOTE: *This indicator is used for children age 5 years and older and who are enrolled in an educational program.*

Determine from Informants, Observations, Plans, and Records

1. Is this child enrolled in an educational program consistent with age and ability? • If not, why not?
2. Does the child's grade level match the child's age? • If not, why not?
3. Is the child assigned to the general education curriculum? • If not, is the child receiving special education and related services in an alternative curriculum directed via an Individual Educational Plan (IEP)?
4. Is the child actively and consistently engaged in the instructional processes and related activities necessary for acquisition of expected skills, competencies, and performances associated with curricular goals and objectives?
5. Is the child reading on grade level or at a level anticipated in an IEP?
6. Is the child meeting curriculum requirement necessary for promotion, course completion, and IEP-directed transitions? • If not, why not?

CHILD/YOUTH STATUS REVIEW 8B: LEARNING & DEVELOPMENT (AGE 5 AND OLDER)

Description and Rating of the Child/Youth's Current Status

NOTE: *This indicator is used for children age 5 years and older and who are enrolled in an educational program.*

Description of the Status Situation Observed for the Child, age 5 years and older	Rating Level
♦ **Optimal Learning Status.** The child is enrolled in a highly appropriate educational program, consistent with age and ability. The child has an excellent rate of school attendance (>95% attendance with no unexcused absences). The child's optimal level of participation and engagement in educational processes and activities is enabling the child to reach and exceed all educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading at or well above grade level or the level anticipated in an IEP. The child may be meeting or exceeding all requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program.	6
♦ **Good Learning Status.** The child is enrolled in a generally appropriate educational program, consistent with age and ability. The child has a substantial rate of school attendance (e.g., >90 <95% attendance with no unexcused absences). The child's good level of participation and engagement in educational processes and activities is enabling the child to reach most educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading at grade level or the level anticipated in an IEP. The child may be meeting most requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program.	5
♦ **Fair Learning Status.** The child is enrolled in an adequate appropriate educational program, consistent with age and ability. The child has a fair rate of school attendance (e.g., >85 <90% attendance with no unexcused absences). The child's fair level of participation and engagement in educational processes and activities is enabling the child to reach at least minimally acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading near grade level or the level anticipated in an IEP. The child may be adequately meeting core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program.	4
♦ **Marginal Learning Status.** The child may be enrolled in a marginally appropriate educational or vocational program, or somewhat inconsistent with age and ability. The child may have an inconsistent rate of school attendance (e.g., >75 <85% attendance and may have tardy notes or unexcused absences). The child's limited level of participation and engagement in educational processes and activities may be hindering the child from reaching at least minimally acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading a year below grade level or somewhat below the level anticipated in an IEP. The child may not be meeting some core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. Concerted action is needed in this area.	3
♦ **Poor Learning Status.** The child may be enrolled in a poor or inappropriate educational program, or inconsistent with age and ability. The child may have a poor rate of school attendance (e.g., <75% attendance and may have been truant). The child's poor level of participation and engagement in educational processes and activities may be preventing the child from reaching acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading two years below grade level or well below the level anticipated in an IEP. The child may not be meeting many core requirements for grade-level promotion, course completion, or successful transition to the next school or vocational program. Concerted action is needed in this area.	2
♦ **Adverse Learning Status.** The child may be chronically truant, suspended, or expelled from school. The child may be three or more years behind in key academic areas, may be losing existing skills and/or regressing in functional life areas, and/or may be confined in detention without appropriate instruction or hospitalized. Concerted action is needed in this area.	1
♦ **Not Applicable.** The child is under the age of 5 or has not been enrolled in a formal educational setting.	NA

CHILD/YOUTH STATUS REVIEW 9: PATHWAY TO INDEPENDENCE (OLDER YOUTH)

PATHWAY TO INDEPENDENCE: To what degree: • Is the youth gaining skills, education, work experience, connections, relationships, income, housing, and necessary capacities for living safely and functioning successfully independent of agency services, as appropriate to age and ability ? • Is the youth developing long-term connections and informal supports that will support him/her into adulthood? [Past 30 days]

NOTE: *This indicator applies to any youth who is age 16 or older. This indicator is looking beyond formal independent living services.*

The goal of assisting a youth is to build the capacities necessary to live safely and to function successfully and independently following services. When these capacities are demonstrated and sustained over time, the need for outside supervision has passed. Indications that the youth is building necessary capacities may include:

- Knowing and using key life skills in solving basic problems related to daily living.
- Taking control of one's needs, issues, and assets and having clear life plans for early adulthood.
- Linking with informal supports and resources in the extended family, neighborhood, and community.
- Reducing social isolation and building social networks that create supports, linkages, and opportunities.
- Setting and achieving important life goals (e.g., vocational training, high school graduation, GED, post-secondary education).
- Finding ways to meet fundamental needs (e.g., income, housing, transportation, health care, food, child care).
- Establishing and maintaining trusting and supportive relationships among family members and supporters.
- Forming and relying on a sustainable support network independent of agency funding or supervision.
- Knowledge of services available through age 21.

Once the youth has reached adulthood and when effective and sustainable support networks are in place, outside supervision can be safely faded and concluded. NOTE: These elements become increasingly important for the youth approaching actual independence.

NOTE: *Unique timeframes are used in rating this indicator. Timeframes for ratings 4 and 5 in this indicator differ from the usual rating timeframes in that both ratings use a 3-month time window.*

Determine from Informants, Observations, Plans, and Records

1. Is the youth gaining competence in learning, navigating, and relying upon community resources, his/her own social networks of people, his/her own problem-solving abilities, and knowledge of his/her living environment?

2. Is the youth linking with informal supports and resources in the extended family, neighborhood, spiritual community, and/or larger community?

3. Is the youth developing and maintaining sustainable, positive, long-term relationships with others necessary for sustainable social supports?

4. Is the youth progressing in his/her education, setting career goals, seeking and using employment opportunities, and progressing toward self-sufficiency?

5. Is the youth setting and achieving functional goals and achievable life plans for living independently upon attainment of adulthood?

6. Is the youth finding acceptable ways to meet fundamental living needs (e.g., income, housing, transportation, health care, food, child care)? • Is the youth forming and relying on sustainable support networks that are independent of public agencies providing supervision and support?

7. Is the youth working? • Does the youth have transition plans for moving from school to work, post-secondary education, or adult services?

8. Is the youth seeking and sustaining affordable housing? • Does the youth have transition plans for supported housing/living services, if needed?

9. Is the youth making adequate progress toward independence, given the amount of time the youth has remaining under supervision or receiving support services? • How well are transition planning and appropriate informal supports integrated into the combination and sequence of strategies being used?

10. Is progress towards independence at a level where supervision can be reduced? • Formal supports faded? • Sustainable, safe case closed?

CHILD/YOUTH STATUS REVIEW 9: PATHWAY TO INDEPENDENCE (OLDER YOUTH)

Description and Rating of the Youth's Pathway to Independence

ALTERNATIVE TIME SCALE USED ON THIS INDICATOR: *This indicator measures a youth's progress in developing independent living skills. It is designed to look retrospectively over the past 6 months for a rating of 6 and over the past 3 months for ratings 4 and 5. This variation in the time scale is used to provide a common 30-day window for good and substantial progress towards independent living skills (rating 5) or steadily increasing independent living skills (rating 4). A 30 day period would be too short to discern a clear pattern of developmental progress if skills continue to improve more and more frequently.*

Description of the Status Situation Observed for the Youth	Rating Level
♦ **Optimal Development.** The youth has been making excellent progress over the past six months in: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making excellent progress in: (1) garnering a living wage; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.	6
♦ **Good Development.** The youth has been making good and substantial progress over the past 3 months: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making substantial progress in: (1) garnering a living wage; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.	5
♦ **Fair Development.** The youth has been making adequate to fair recent progress over the past 3 months: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making fair progress in: (1) garnering a living wage; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.	4
♦ **Marginal Development.** The youth has been making limited or inconsistent progress over the past 30 days: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making limited progress in: (1) garnering a living wage; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary. Concerted action is needed in this area.	3
♦ **Poor Development.** The youth has been making slow, inadequate progress over the past 30 days: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making little progress in: (1) garnering a living wage; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary. Concerted action is needed in this area.	2
♦ **No Development.** The youth has been making no progress over the past 30 days: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is not progressing toward: (1) garnering a living wage; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary. Concerted action is needed in this area.	1
♦ **Not Applicable.** The child or youth is under age 16 years and does not have a goal or concurrent plan that addresses independence; therefore, this indicator does not apply.	NA

SECTION 2

PARENT/CAREGIVER STATUS INDICATORS

PARENT/CAREGIVER STATUS REVIEW 1A: PARENTING CAPACITIES (HOME SETTINGS)

PARENTING CAPACITIES: To what degree: • Does the parent/resource parent(s) demonstrate adequate parenting capacities on a reliable daily basis commensurate with that required to provide the child(ren) with appropriate nurturance, guidance, protection, care, education, and supervision? • If the child(ren) has special medical, emotional, behavioral, and/or developmental needs, does the parent/caregiver have and use any special knowledge, skills, and supports that may be required to meet the needs of the child(ren)? [Past 30 days]

Parents/resource parents should have and use levels of knowledge, skills, and situational awareness necessary to provide their children with nurturance, guidance, age-appropriate discipline, and supervision necessary for protection, care, and normal development. Understanding the basic developmental stages that children experience, relevant milestones, expectations, and appropriate methods for shaping behavior is key to parental capacity to support their child(ren)'s healthy growth and learning.

Parenting children with unique medical, developmental, emotional, and/or behavioral challenges can require additional specialized knowledge and resources. Parents who are faced with extraordinary caregiving demands may require additional support, including relief and respite care. The goal of assisting a family who needs assistance with parental capacity is to ensure that the family receives the information, assistance, and/or training needed to demonstrate that they have the basic skills and supports necessary to meet their unique children's needs. Interventions should be an appropriate match to parent and child circumstances, learning styles, and culture. This indicator does not apply to a child or youth whose caregivers are staff in congregate care settings. The reviewer should use Status Review 2B: Caregiving Capacities (Congregate Settings).

Determine from Informants, Observations, Plans, and Records

1. Can the family perform appropriate parenting skills adequately, reliably, and consistently on a daily basis for this child and other children at home?

   - Is the family/resource family's home free of hazards that might endanger the children?
   - Are the children in the home appropriately supervised?
   - If there are older youth in the home, do they have appropriate age-appropriate expectations, curfews, and consequences?
   - Are the children attending school on a daily basis and doing their homework?
   - Do the parents/resource parents attend parent-teacher conferences and special school events?
   - Do the parents attend planned visitations with their children (if they are placed out of home)?
   - Do the parents use praise, show affection and emotional support, and use age-appropriate discipline with the child?
   - If the family lives in an unsafe neighborhood, does the family identify reasonable ways and means to help their children protect themselves?

2. Are there extraordinary demands placed on the caregiver of this family, such as small children, high child/caregiver ratio, frail elderly, ill persons in the home, single parent family, or social isolation? • If yes, what impact do these demands place on the primary caregiver(s)? • What other supporters are available to offset and manage an extraordinary care burden?

3. Are there extraordinary demands placed on the caregiver of this family, such as a child with a special health or medical condition, physical, developmental, emotional, or behavioral disability? • If yes, explain the child's needs and family circumstances. • If yes, what impact do these demands place on the primary caregiver(s)? • What other supporters are available to offset and manage an extraordinary care burden?

4. How well do the parents/resource parents exercise unified and effective authority in setting and meeting family goals?

5. Are proper boundaries maintained between family members; e.g., not overly enmeshed or isolated?

6. Is a proper balance of power maintained between the parents and between the parents and children?

7. Do family members promote scape-goating one or more of the members?

8. Do the parents/resource parents seem appropriately warm and nurturing toward the child as opposed to being cold, distant, and punitive?

9. Are the family building, extending, and using formal and informal resources, supports, and social networks? • Is the family excessively open or closed in relation to the outside community?

PARENT/CAREGIVER STATUS REVIEW 1A: PARENTING CAPACITIES (HOME SETTINGS)

Description and Rating of the Parent/Caregiver Current Status

NOTE: *When scoring this indicator, both mother and father, as well as resource parent(s) (if applicable), should be included. If parental rights have been terminated, then the mother and father rating options are marked NA. If the child has been adopted, then score the adoptive parents as mother and father. If there is insufficient information to determine the parenting capacities of an absent parent, then that parent should be marked NA.*

A resource parent is defined as any person or people caring for a child placed outside of the family home aside from congregate care

Description of the Status Situation Observed for Mother, Father and/or Resource Parent	Rating Level
♦ **Optimal Parenting Capacities.** The parents/resource parents demonstrates excellent and enduring parenting capacities on a reliable daily basis at or above that required to provide the child with appropriate nurturance, guidance, protection, care, education, and supervision. If the child has special medical, emotional, behavioral, educational, and/or developmental needs, the parent/resource parent demonstrates optimal knowledge and excellent use of specialized skills and supports that may be required to meet the needs of the child.	**6** ■ Mother ■ Father ■ Resource Parent
♦ **Good Parenting Capacities.** The parents/resource parents demonstrates good and consistent parenting capacities on a reliable daily basis at or above that required to provide the child with appropriate nurturance, guidance, protection, care, education, and supervision. If the child has special medical, emotional, behavioral, educational, and/or developmental needs, the parent/resource parent demonstrates good working knowledge and proficient use of specialized skills and supports that may be required to meet the needs of the child.	**5** ■ Mother ■ Father ■ Resource Parent
♦ **Fair Parenting Capacities.** The parents/resource parents demonstrates adequate to fair parenting capacities on a reliable daily basis at a level required to provide the child with appropriate nurturance, guidance, protection, care, education, and supervision. If the child has special medical, emotional, behavioral, educational and/or developmental needs, the parent/resource parent demonstrates at least adequate working knowledge and use of specialized skills and supports that may be required to meet the needs of the child.	**4** ■ Mother ■ Father ■ Resource Parent
♦ **Marginal Parenting Capacities.** The parents/resource parents demonstrates a limited or inconsistent pattern of parenting capacities on a daily basis, sometimes or somewhat less than the level required to provide the child with adequate nurturance, guidance, protection, care, education, and supervision. If the child has special medical, emotional, behavioral, educational and/or developmental needs, the parents/resource parents demonstrate somewhat inadequate working knowledge and ineffective use of specialized skills and supports that may be required to meet the needs of the child. Concerted action is needed in this area.	**3** ■ Mother ■ Father ■ Resource Parent
♦ **Poor Parenting Capacities.** The parents/resource parents demonstrates an inadequate pattern of parenting capacities some or most of the time, often less than the level required to provide the child with adequate nurturance, guidance, protection, care, education, and supervision. If the child has special medical, emotional, behavioral, educational and/or develop mental needs, the parents/resource parents demonstrate inadequate working knowledge and ineffective use of specialized skills and supports that may be required to meet the needs of the child. Concerted action is needed in this area.	**2** ■ Mother ■ Father ■ Resource Parent
♦ **Adverse Parenting Capacities.** The parents/resource parents demonstrate a seriously inadequate pattern of parenting capacities most of the time, offering much less than the level required to provide the child with adequate nurturance, guidance, protection, care, education, and supervision. If the child has special medical, emotional, behavioral, educational and/or developmental needs, the parents/resource parents lack working knowledge and ineffective use of specialized skills and supports that may be required to meet the needs of the child. Concerted action is needed in this area.	**1** ■ Mother ■ Father ■ Resource Parent
♦ **Not Applicable.** Under any of the following conditions, this indicator may not apply to one or more of the persons being rated: • If the child is living in the parent's home, then the resource parent option would not be rated. • If parental rights have been terminated, then the parent(s) option would not be rated. • If the focus child resides in a 24-hour staffed facility (e.g., hospital, residential treatment facility, detention center, nursing home, etc.), then the resource parent option would be marked NA.	**NA** ■ Mother ■ Father ■ Resource Parent

PARENT STATUS REVIEW 1B: CAREGIVING CAPACITIES (CONGREGATE SETTINGS)

CAREGIVING CAPACITIES: To what degree are the child's primary caregivers in the group home or residential treatment center (RTC) supporting the education, development, and independence of the child/youth adequately on a consistent daily basis [as appropriate to age and need]? [Past 30 days]

NOTE: *This indicator applies to a child who is living in a congregate setting. If the child is returning to a family, kinship, foster home, or adoptive home then both Parenting Capacities and Congregate Setting Indicators should be rated.*

The child's group home/RTC should have one or more primary caregivers who are willing, available, and able to parent the child daily by:

- Assisting with the child's education by ensuring daily school attendance, assisting with homework and special projects.
- Encouraging and supporting the child's participation in extracurricular activities or youth's pathway to independent living and work.
- Attending parent-teacher conferences, planning special services, and attending special school events.
- Meeting the child's basic needs for food, shelter, clothing, hygiene, and health care.
- Recognizing and responding to the unique needs of children arising from their histories of trauma, neglect, disruption, and loss.
- Following through at the group home/ RTC on special educational or therapeutic interventions for a special needs child.
- Meeting the child's basic emotional needs through praise, affection, emotional support, and age-appropriate discipline.
- Knowing the child's friends, pattern of activities, and whereabouts and providing oversight in reducing risk situations.
- Providing adequate supervision, feedback about behavior, corrective instruction, and logical consequences for misbehavior.
- Providing guidance and moral reasoning as the child moves through life stages and works through typical life problems.

These are **routine primary caregiver responsibilities and activities** that meet a child's needs for health, safety, love, attention, caring, development, socialization, education, and independence. They also provide a basis for developing a conscience, character, and good habits essential for personal responsibility. Primary caregiver activities should be done on an age-appropriate basis for the child in a group home/ RTC. The primary focus of this review is on caregiver-provided supports necessary for the child/youth to be ready to learn, participate in school activities, and benefit from educational opportunities.

Determine from Informants, Observations, Plans, and Records

1. Who is the primary caregiver in the group home/ RTC for this child (afternoon, evening, and weekend shifts)?

2. Are the child's basic and special needs met on a consistent daily basis?

3. Does the child come to school ready to learn and to participate? • Is the child attending school/work on a daily basis? •Does the child complete homework and special project assignments? • Do the child's caregivers attend teacher conferences, IEP meetings, and other activities related to the child's needs and progress?

4. Is the child encouraged/supported in participating in extracurricular activities provided through the school or other organizations?

5. Do the primary caregivers spend time with the child on a regular basis in support of school and education-related activities?

6. Are the child's emotional needs met through praise, affection, emotional support, and age-appropriate discipline?

7. Do the caregivers know their children's friends, activity patterns, and whereabouts and provide oversight necessary to reduce risks of harm to the children?

8. Do the caregivers provide adequate supervision, feedback about behavior, corrective instruction, and logical consequences for misbehavior, including the child's school behavior and academic/work performance?

9. As the child develops through his/her adolescence and teenage years, are caregivers able to assist him/her with making critical life decisions regarding education, vocation, employment, sexuality, reproductive health care, religion, morality, and the use of substances?

10. Do the caregivers provide positive rewards, feedback about behavior, and corrective instruction and use logical consequences for misbehavior?

11. Are supports and services being provided to assist caregivers in the group home/ RTC? • If so, do these seem to be adequate in meeting the needs of the child and caregivers? • Do the caregivers have access to sufficient and ongoing training?

PARENT STATUS REVIEW 1B: CAREGIVING CAPACITIES (CONGREGATE SETTINGS)

Description and Rating of the Caregiver's Current Status

NOTE: *This indicator applies to a child who is living in a congregate setting. If the child is returning to a family, kinship, foster home, or adoptive home then both Parenting Capacities and Congregate Setting Indicators should be rated.*

Description of the Status Situation Observed for the Child and Current Caregiver	Rating Level

- **Optimal Caregiving.** The child is benefiting from his/her educational opportunities as shown through excellent academic achievement. The child's basic needs, including food, shelter, clothing, hygiene and health care are consistently met. Caregivers provide nurturance, discipline, logical consequences, and moral upbringing. Caregivers participate fully in conferences, planning services, and special events. The caregivers provide excellent supervision, emotional support and therapeutic interventions as needed to assist the child in positive growth and development. For older youth, caregivers provide independent living supports. **6**

- **Good Caregiving.** The child usually benefits from his/her educational opportunities as shown through good academic achievement. The child's basic needs, including food, shelter, clothing, hygiene and health care are generally met. Caregivers usually provide nurturance, discipline, logical consequences, and moral upbringing. Caregivers participate fully in conferences, planning services, and special events. The caregivers provide adequate supervision, emotional support and therapeutic interventions as needed to assist the child in positive growth and development. For older youth, caregivers usually provide independent living supports. **5**

- **Fairly Adequate Caregiving.** The child/youth adequately benefits from his/her educational opportunities as shown through fair academic achievement. The child's basic needs, including food, shelter, clothing, hygiene and health care are fairly met. Caregivers usually provide nurturance, discipline, logical consequences, and moral upbringing. Caregivers occasionally participate in conferences, planning services, and special events. The caregivers provide fairly adequate supervision, emotional support and therapeutic interventions as needed to assist the child in positive growth and development. For older youth, caregivers usually provide independent living supports. **4**

- **Marginal - Minor, Occasional Problems in Caregiving.** The child is benefiting little from his/her educational opportunities as shown through poor academic achievement. The child's basic needs, including food, shelter, clothing, hygiene and health care are inconsistently met. Caregivers provide inadequate or inappropriate nurturance, discipline, logical consequences, and moral upbringing. Caregivers seldom participate in conferences, planning services, and special events. The caregivers provide inconsistent or inadequate supervision, emotional support and therapeutic interventions as needed to assist the child/youth in positive growth and development. For older youth, caregivers usually provide independent living supports. Follow-through with special interventions is limited. Minor support problems are present. Concerted action is needed in this area. **3**

- **Poor - Moderate and Continuing Problems in Caregiving.** The child's educational status is questionable as shown through poor academic achievement. The child is likely to be doing poorly in school, sick, absent, truant, suspended, or expelled. The child's basic needs, including food, shelter, clothing, hygiene and health care are unable to be met for some period of time. Caregivers provide inadequate or inappropriate nurturance, discipline, logical consequences, and moral upbringing. Caregivers seldom participate in conferences, planning services, and special events. Appropriate supervision, emotional support and therapeutic interventions as needed to assist the child/youth in positive growth and development has lapse for extended periods of time. Discipline may be absent, inappropriate, or excessive. For older youth, caregivers seldom provide independent living supports. Follow-through with special interventions is limited. Moderate support problems and their consequences are present. Concerted action is needed in this area. The child rarely comes to school prepared and ready to learn. Any benefit from his/her educational opportunities is questionable, as shown through poor academic achievement. The caregiver may be unable to meet the direct care needs of the child for some period of time. Basic care of children, supervision, and assistance lapse for extended periods of time. The child is likely to be doing poorly in school, sick, absent, truant, suspended, or expelled. Discipline may be absent, inappropriate, or excessive. Moderate support problems and their consequences are present. Concerted action is needed in this area. **2**

- **Adverse - Serious and Worsening Problems in Caregiving.** The child does not come to school prepared and ready to learn and is not benefiting from his/her educational opportunities, as shown by failing academic performance. The caregiver may be unable to meet the direct care needs of the child for some period of time for an extended period of time. There is serious concern regarding basic care, supervision, and assistance for the children. The child is most likely doing poorly in school, sick, absent, truant, suspended, or expelled. Discipline is absent, inappropriate, or excessive. Serious support problems and their consequences are present. Concerted action is needed in this area. **1**

- **Not Applicable.** The child does not reside in a congregate care home or RTC at this time. **NA**

PARENT STATUS REVIEW 2: INFORMAL SUPPORTS

INFORMAL SUPPORTS: To what degree: • Is the family/resource family engaged with an informal support system that assists them with essential care giving responsibilities? • Do families having special needs children/youth, recovery/relapse prevention plans, and/or family safety plans have adequate levels of informal support provided by family, friends, neighbors, or other supporters involved who will help them manage adequately on an enduring basis? • When a family has a child/youth with special needs (physical, developmental, emotional, behavioral), do parents/resource parent(s) have opportunities to exchange experiences, strategies, and successes with parents of similar circumstances? [Past 30 days]

NOTE: *This indicator is rated for mother and father and/or a resource parent(s) where the child may currently live. Thus, this indicator is applied to both mother and father and resource parent(s). If TPR has occurred and the adoption has not been finalized, but is living in a congregate care setting, then the indicator is scored Not Applicable (NA). If there is insufficient information to determine the informal supports of an absent parent, then that parent should not be taken into consideration when rating this indicator.*

The focus of this indicator is placed on the adequacy and durability of the family/resource family supports in helping parents/resource parents succeed in parenting the child(ren). Parents/resource parents need meaningful connections with family members, friends, neighbors, and others in their community to support their parenting ambitions and efforts. Family members and social networks provide caregivers with important supports, knowledge, linkages, and opportunities. Informal supports can be a family resource in many different ways around parenting issues:

- Gaining and using key life skills in solving basic problems related to daily living and parenting of children.
- Finding ways to meet fundamental needs (e.g., income, housing, transportation, health care, food, child care).

Establishing and maintaining trusting, supportive relationships among family members and key supporters is essential for families who have special needs children, relapse prevention plans, and/or safety plans that will facilitate and sustain their long-term success. When families/resource families have an already functioning informal network, the goal of interveners is to engage, join, and build on their capacity to support the caregivers. At times, the goal of interveners may be to assist a family to extend or replace, and maintain a set of informal supports and community connections.

Determine from Informants, Observations, Plans, and Records

1. Who are the people serving as important supports to the family/resource family (e.g., willing family members, close friends, helpful neighbors, or other helping persons, such as members of the faith community or voluntary social service organization for parents)?

2. What role or contribution do they make in the family's life? • What levels of supports are being provided to the child and/or family/resource family? • For what types of family needs? • How many hours per month?

3. Are mothers, fathers and resource parents using appropriate mutual support groups in the community (e.g., parents of newborns, Parents Anonymous, NA sponsors, Alcoholics Anonymous, Big Brothers/Big Sisters, etc.)?

4. Are mothers, fathers and resource parents involved in neighborhood and community educational and recreational activities?

5. Have formal services/supports been able to be reduced or withdrawn as a result of the informal supports accessed by the family?

6. Is an expanded circle of informal support needed to help the family/resource family achieve and sustain the conditions necessary for sustainable, safe case closure?

7. Is local law enforcement involved as necessary to enforce no-contact orders or to respond to calls for assistance during/following an episode of domestic violence involving a person in the household?

8. Overall, how adequate (reliable and sustainable) is the family's/resource family's support system for helping members move through the family change process to the attainment of outcomes and ending requirements for gaining family independence from the system and leading to sustainable, safe case closure?

PARENT STATUS REVIEW 2: INFORMAL SUPPORTS

Description and Rating of the Mother/Father/Resource Parent Current Status

NOTE: *When scoring this indicator, both mother and father as well as resource parents should be included. When scoring each parent is scored separately and resource parent is scored if child is in out of home placement(not in congregate care) If parental rights have been terminated, then the mother/father rating options are marked NA. If the child has been adopted, then the score for the adoptive parents would be marked under the mother/father. If there is insufficient information to determine the informal supports of an absent parent, then that parent should not be taken into consideration when rating this indicator.*

Description of the Status Situation Observed for Mother/Father/Resource Parent	Rating Level
♦ **Optimal Informal Supports.** The mother/father/resource parent has and uses excellent, ongoing assistance through a combination of appropriate informal supports offered in the home, neighborhood, and community. Where necessary, any extraordinary demands placed on the caregiver are fully balanced with training, practical assistance, support, and relief to meet the needs of the child and maintain stability of the home. If the family has a child with special needs, the mother/father/resource parent have and rely on excellent opportunities to exchange experiences, strategies, and successes with parents of similar circumstances.	**6** ■ Mother ■ Father ■ Resource Parent
♦ **Good Informal Supports.** The mother/father/resource parent has and uses substantial and dependable assistance through a combination of appropriate informal supports offered in the home, neighborhood, and community. Where necessary, any extraordinary demands placed on the caregiver are substantially balanced with training, practical assistance, support, and relief to meet the needs of the child and maintain the stability of the home. If the family has a child with special needs, the mother/father/resource parent have and rely on many helpful opportunities to exchange experiences, strategies, and successes with parents of similar circumstances.	**5** ■ Mother ■ Father ■ Resource Parent
♦ **Fair Informal Supports.** The mother/father/resource parent has and uses adequate to fair assistance through several, occasional appropriate informal supports offered in the home, neighborhood, and community. Where necessary, any extraordinary demands placed on the caregiver are adequately balanced with training, practical assistance, support, and relief to meet the needs of the child and maintain the stability of the home. If the family has a child with special needs, the mother/father/resource parent have and rely on a few helpful opportunities to exchange experiences, strategies, and successes with parents of similar circumstances.	**4** ■ Mother ■ Father ■ Resource Parent
♦ **Marginal Informal Supports**. The mother/father/resource parent has and uses limited and inconsistent assistance through few appropriate informal supports offered in the home, neighborhood, or community. Where necessary, any extraordinary demands placed on the caregiver are inconsistently balanced with training, practical assistance, support, and relief to meet the needs of the child and maintain the stability of the home. If the family has a child with special needs, the mother/father/resource parent rarely have helpful opportunities to exchange experiences, strategies, and successes with parents of similar circumstances. Concerted action is needed in this area.	**3** ■ Mother ■ Father ■ Resource Parent
♦ **Poor Informal Supports.** The mother/father/resource parent has poor or generally inadequate assistance from rarely provided appropriate informal supports offered in the home, neighborhood, or community. Where necessary, any extraordinary demands placed on the caregiver are not balanced with training, practical assistance, support, and relief to meet the needs of the child and maintain the stability of the home. If the family has a child with special needs, the parents/caregivers seldom have any opportunities to exchange experiences, strategies, and successes with parents of similar circumstances. Concerted action is needed in this area.	**2** ■ Mother ■ Father ■ Resource Parent
♦ **Absent or Adverse Supports.** The mother/father/resource parent has serious problems in securing helpful appropriate informal supports offered in the home, neighborhood, or community. Some persons' involvement may undermine parent capacities or motivations. Where necessary, any extraordinary demands placed on the caregiver may be overwhelming without having training, practical assistance, support, and relief to meet the needs of the child and maintain the stability of the home. If the family has a child with special needs, the mother/father/resource parent may lack opportunities to exchange experiences, strategies, and successes with parents of similar circumstances. Concerted action is needed in this area.	**1** ■ Mother ■ Father ■ Resource Parent
♦ **Not Applicable.** Under any of the following conditions, this indicator may not apply to one or more of the persons being rated: • If the child is living in the parent's home, then the resource parent option would not be rated. • If parental rights have been terminated, then the mother/father option would not be rated. • If the focus child has resided in a 24-hour staffed facility (e.g., hospital, residential treatment facility, detention center, nursing home, etc.) for the past 90 days and is not expected to return to the parent's home or to another resource parent within the next 30 days, then neither option is rated and only the Congregate Care 1B rating is applied.	**NA** ■ Mother ■ Father ■ Resource Parent

SECTION 4

SYSTEM PERFORMANCE

Indicators of Practice Performance **Page**

PRACTICE REVIEW 1: ENGAGING ROLE & VOICE OF MOTHER/FATHER/CHILD/RESOURCE PARENT

ROLE & VOICE: To what degree are family members with whom the child/youth is living and/or will be reunited, active ongoing participants (e.g., having a significant role, voice, influence) in decisions made about child/family change strategies, services, and results? They are active participants in the plans and services they have identified. They have a plan for positive outcomes for the child/family. A trust-based relationship exists between all team members. [Last 90 Days/Past 12 Months]

The family change process belongs to the family as led by the parents and/or resource parent(s) for the child who may be the concurrent permanency alternative for the child. The child's parent and/or resource parent should be full and effective partner(s) on the team, fully participating in all aspects of assessment, service planning, implementation, monitoring, and evaluation of results for the child and family. School-aged children and above (as developmentally appropriate) should also be "actively involved" which means that the agency has consulted with the child regarding the child's goals and services, explained the plan and terms used in the plan in a language that the child can understand. The child is also included in periodic case planning, especially if any changes are being considered in the plan. Through a trust-based relationship the child (as appropriate) and parents and/or resource parents (as appropriate) have a central and directive role providing a voice that shapes the course and pace of decisions made by the team on behalf of the child and family. Ownership, leadership, full-participation, commitment, and follow-through by the parents and/ or resource parents are essential to behavioral change.

The same Role and Voice applies to the education and treatment of children. As the child's first and foremost teacher and as the child's legal and primary advocate, the parents and/or resource parents should be able, active, and ongoing partner(s) in the child's development, education, and/or treatment. Ideally, the parents and/or resource parent should support the child's development by:

- Knowing and explaining the child/family's strengths, needs, preferences, and challenges so that others may understand and assist.
- Understanding, accepting, and working toward any non-negotiable conditions that are essential for child safety, well-being, and permanency.
- Attending team meetings and shaping key decisions about life goals, intervention strategies, special services, and essential supports.
- Fulfilling a lead role and providing the voice and views of the child and family when advocating for needs, supports, and services.
- Following through at home on developmental, educational, therapeutic, or medical interventions for a special needs child.
- Participating fully in the change process which over time becomes behavior change versus passive acceptance (compliance).

To fulfill the role of parent, child/family advocate, and supporter, the parents and/or resource parent should be engaged as a leader and active partner in assessing needs, making plans, implementing and monitoring services, and evaluating results and outcomes. In some cases, parents/resource parents may experience circumstances that reduce their ability or opportunity to participate as a major partner. A working single caregiver may lose income if required to attend meetings during school/work hours. Caregivers with extraordinary demands in the home or with special needs of their own may have difficulty participating without special accommodations or support. The family team has an obligation to engage the caregiver as a partner in decision making, to make accommodations and provide supports where necessary to facilitate their participation.

Determine from Interviews, Observations, and Reviews of Plans and Records

1. To what degree is the family change process owned by and led by the child, parents or resource parents?

2. How well is the parent fulfilling an appropriate lead role in providing the voice and views of the family when advocating for needs, supports, and services? • How was the family team leader selected? • What does the child, parents, and/or resource parents want and need? • Can they speak freely? • Do others listen? • Did the child, parents, and/or resource parent assist with identifying what needs to be done?

3. At what level is the child's parents voice heard and used to influence key decisions? • Do child/family team members understand and accept any non-negotiable requirements or conditions necessary for safety, well-being, and permanency? • How well is the family engaged to participate? Does the child's, parents', resource parent's, voices **appropriately** influence key decisions to promote behavioral change?

4. Has the child, parents, and/or resource parent(s) been informed (full disclosure) of the concurrent plans? • Did the child, parents, and/or resource parent(s) have the opportunity to provide input into a primary plan and concurrent plan?

5. How often do the child's parents/resource parent(s) attend teacher conferences, family team meetings, and other activities related to the needs and progress of the child? • How well do the child's parents/resource parent(s) know and explain child and family strengths, needs, challenges, and preferences to others involved in the services processes?

6. Are there factors that substantially and repeatedly prevent or reduce the parent/resource parent's opportunity or ability to function as an advocate for the family in the family change process? • If so, what are these factors? What supports are provided to enhance the child's, parent's and/or resource parent's role and voice in decisions?

7. If there are factors that substantially and repeatedly prevent or reduce the child's, parents/resource parents opportunity or ability to function effectively in matters related to the child's service needs, has the family team offered special accommodations or supports to the parents/resource parents to facilitate effective participation? • If so, have they been accepted by the parent/resource parent and has this improved participation? • If accommodations or supports have not been offered, why not?

8. If the parent/resource parent is unable to function as an effective partner and advocate for the child in education and special service needs, has a qualified surrogate advocate been assigned by the school to serve as an advocate for this child? • If not, why not? • If so, is this person functioning as a knowledgeable and prepared advocate for the child?

PRACTICE REVIEW 1: ENGAGING ROLE & VOICE MOTHER/FATHER/CHILD/RESOURCE PARENT

Description and Rating of Role & Voice of Mother/Father/Child/Resource Parent

NOTE: *This indicator applies to the child, mother, father, and/or resource parent of the child. If termination of parental rights has been filed and efforts ceased, then the mother/father rating options are marked NA; however, if the presiding Judge rules that services must continue for the mother/father, then the appropriate indicator **would** be scored. If adoption has been finalized, the adoptive parents should be rated as Mother and Father. Select Not Applicable (NA) if the child is not old enough to participate in case planning or is incapacitated. Although the capacity to participate actively in case planning will need to be decided on a case-by-case basis, as a guideline, most children who are elementary school-aged or older are expected to participate to some extent.*

Description of the Status of Family Members (as appropriate to the present situation)	Rating Level
♦ **Optimal Family Role & Voice.** The child, parent and/or resource parent (as appropriate) have a central and directive role, providing a voice that **appropriately** shapes the agreed-upon course and pace of decisions made by the team on behalf of the child and family. Key team members are full and effective partner(s) on the team, fully participating in all aspects of assessment, service planning, implementing, monitoring, and evaluating results for the child and family **in achieving positive outcomes.**	**6** ■ Mother ■ Father ■ Child ■ Resource Parent(s)
♦ **Good Family Role & Voice.** The child, parent and/or resource parent (as appropriate) have a present and effective role, providing a voice that **generally** influences the course and pace of decisions made by the team on behalf of the child and family. Key team members are substantial and contributing partners on the team, generally participating in most aspects of assessment, service planning, implementing, monitoring, and evaluating the results **in achieving positive outcomes.**	**5** ■ Mother ■ Father ■ Child ■ Resource Parent(s)
♦ **Fair Family Role & Voice.** The child, parent and/or resource parent (as appropriate) have an adequately effective role, providing a voice that **somewhat** suggests and affirms the course and pace of decisions made by the team on behalf of the child and family. Key team members are fair participant(s) in some aspects of team decision making, minimally participating in some assessment, service planning, implementation, monitoring, and evaluating the results **in achieving positive outcomes.**	**4** ■ Mother ■ Father ■ Child ■ Resource Parent(s)
♦ **Marginal Family Role & Voice.** The child, parent and/or resource parent (as appropriate) have a marginal role, providing a some what passive voice that acknowledges or accepts the course and pace of decisions made by the team on behalf of the child and family. Key team members are limited or inconsistent participant(s) in a few aspects of assessment, service planning, implementing, monitoring, and evaluating the results. The parent/caregiver may have limiting circumstances, may not have been offered accommodations or supports, or may not wish greater participation even with offered accommodations or assistance. Concerted action is needed in this area.	**3** ■ Mother ■ Father ■ Child ■ Resource Parent(s)
♦ **Poor Family Role & Voice.** The child, parent and/or resource parent (as appropriate) have a missing or silent role or passive voice that tacitly accepts or possibly rejects the course and pace of decisions made by the team on behalf of the child and family. Key team members seldom participate in any aspects of assessment, service planning, implementing, monitoring, and evaluating the results. The parent/caregiver may have challenging circumstances, may not have been offered acceptable accommodations or supports, or may not wish greater participation even with offered accommodations or assistance. Concerted action is needed in this area.	**2** ■ Mother ■ Father ■ Child ■ Resource Parent(s)
♦ **Absent or Adverse Family Role & Voice or Advocacy, if needed.** The child, parent/resource parent may be experiencing overwhelming life circumstances without the benefit of special accommodations for support or participation. Key team members have not participated in any aspects of assessment, service planning, implementing, monitoring, and evaluating of results within the past six months or since the last team meeting (whichever is the more recent time event). Concerted action is needed in this area.	**1** ■ Mother ■ Father ■ Child ■ Resource Parent(s)
♦ **Not Applicable.** Person cannot exercise a role and voice (e.g., TPR, the cognitive ability of the child or a no contact order is in place) at this time or there is no such person in this case.	**NA** ■ Mother ■ Father ■ Child ■ Resource Parent(s)

PRACTICE REVIEW 2: TEAMING [FORMATION & FUNCTIONING]

TEAM FORMATION: To what degree: • Have the people who provide support and services for this child/youth and family been identified and formed into a working team? • Does the team have the skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background to achieve positive results with the child and family? TEAM FUNCTIONING: To what degree: • Do members of the family team collectively function as a unified and coordinated team in planning services and evaluating results? • Do actions of the family team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the child/youth and family in achieving positive results? [Last 90 Days/Past 12 Months]

This review focuses on the structure and functional performance of the family team in conducting ongoing collaborative problem solving, providing effective services, and achieving **positive results with the child and family**. Parents/caregivers, professionals, paid service providers, family friends and supporters from the extended family, church, school, or neighborhood and community partners may comprise a service/support team for the child and family. The **principle of proportionate response** is applied in team formation; that is, the team should be no bigger than necessary to understand the family situation, provide support and services for the change process, and provide funding necessary for the child/family change processes. Simple situations may require small teams while complex, dynamic, and risky situations may require teams of sufficient capacity to understand the situation, plan and provide strategies, and provide sustainable supports during and after the intervention process. There is no fixed formula for team size or composition. Broad team representation may be necessary to assure that a necessary combination of technical skills, cultural knowledge, personal interests, and contributions are formed and maintained for the child and family. Collectively, the team should have the technical and cultural competence, family knowledge, authority to act on behalf of funders and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the child/family. A trained facilitator may be used to guide the team process. Team functioning and decision-making processes should be consistent with the principles of family-centered practice and system of care operations. Evidence of effective team functioning lies in its performance over time and in the results it achieves for the child and family. The focus and fit of services, authenticity of relationships and commitments, unity of effort, dependability of service system performance, and connectedness of the child and family to critical resources all derive from the functioning of the family team. The **principles of unity of effort and commonality of purpose** apply to team functioning. Present child status, family participation and perceptions, and achievement of effective results are important indicators about the functionality of the family team.

Determine from Informants, Observations, Plans, and Records

1. Was the family encouraged to invite people who provide informal supports as well as those who influence the course of the case to be on the team? • What family members, friends, and supporters does the family invite? • Are meetings scheduled at times that are convenient for key team members?

2. Are key family members along with professionals, funders, and informal supporters involved in planning and guiding services? • Are people with similar backgrounds to the family members of the team? • Which members did the family invite to participate? • Does the family believe that these are the right people? • As necessary in domestic violence situations, are law enforcement/batterer intervention specialists involved to ensure safety?

3. How well is the family satisfied with the composition and functioning of the team? • Can the child or family request a team meeting at any time?

4. Does the team have a common conceptualization and "big picture" understanding of the history, strengths, hopes, aspirations, stressors, risks, and needs of the family? • Who determined the goals for this family? • Do the goals and strategies set by the team reflect the values of the family?

5. Does the team have the technical and cultural competence, family knowledge, authority to act on behalf of funders and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs of this child and family? • Is a trained family team facilitator used?

6. Do team members commit and ensure dependable delivery of services and resources for the child/family? • Are all members of the team kept fully informed (via email, phone calls, etc.) of the status of the child and family and the implementation of planned services?

7. Are the team's family change strategy and action decisions well-reasoned in design with service efforts integrated and coordinated across service-providing agencies involved with the child and family? • Does the family team have access to and use flexible funding, informal resources, and generic services as appropriate to the permanency plan and to the sustainable, safe case closure conditions set by, for, and with the family?

8. Do family team actions and decisions reveal a pattern of consistent, coordinated, and effective problem solving for this child and family **to achieve positive results**? • What are the present results? • What **progress** is being made in meeting necessary conditions for sustainable, safe case closure and family sustainability?

PRACTICE REVIEW 2: TEAMING [FORMATION & FUNCTIONING]

Description and Rating of Practice Performance

NOTE: *If the case being reviewed is an Assessment, then the reviewers would mark NA under the Team Functioning indicator.*

Description of the Practice Performance Situation Observed for the Child and Family's Family Team — Rating Level

- **Optimal Teaming.** FORMATION: All of the people who provide supports and services for this child and family have been identified and formed an excellent working team. The team has excellent skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. FUNCTIONING: Members of the family team collectively function as a fully unified, coordinated, and consistent team in planning services and evaluating results. Actions of the family team fully reflect an excellent coherent pattern of effective teamwork and fully collaborative problem solving that optimally benefits the child and family **in achieving positive results**. Pattern of 6 months.

  6
  - Formation
  - Functioning

- **Good Teaming.** FORMATION: Most of the people who provide supports and services for this child and family have been identified and formed a good and dependable working team. The team has good and necessary skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. FUNCTIONING: Members of the family team generally function as a substantially unified, coordinated, and consistent team in planning services and evaluating results. Actions of the family team consistently reflect a substantially coherent pattern of effective teamwork and generally collaborative problem solving that generally benefits the child and family **in achieving positive results**.

  5
  - Formation
  - Functioning

- **Fair Teaming.** FORMATION: Some of the people who provide supports and services for this child and family have been identified and formed an adequate to fair working team. The team has adequate to fair skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. FUNCTIONING: Members of the family team may function as a somewhat unified, coordinated, and consistent team in planning services and evaluating results. Actions of the family team usually reflect a fairly coherent pattern of effective teamwork and somewhat collaborative problem solving that at least adequately benefits the child and family **in achieving positive results**.

  4
  - Formation
  - Functioning

- **Marginal Teaming.** FORMATION: Some of the people who provide supports and services for this child and family have been identified and a few have formed a marginal working team. The group has limited or inconsistently used skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. Concerted action is needed in this area. FUNCTIONING: Members may function as a somewhat splintered, uncoordinated, and inconsistent group in planning services and evaluating results. Actions of the group usually reflect a somewhat incoherent pattern of teamwork and limited collaborative problem solving that seldom benefits the child and family **in achieving positive results**. Concerted action is needed in this area.

  3
  - Formation
  - Functioning

- **Poor Teaming.** FORMATION: Few, if any, of the people who provide supports and services for this child and family have been identified to form a working team. Persons involved with the family may have few or inconsistently used skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. Concerted action is needed in this area. FUNCTIONING: People may often function independently of the child/family and/or in isolation of other interveners in planning services and evaluating results. Actions reflect an infrequent or rare pattern of teamwork or collaborative problem solving. This situation may limit benefits for the child and family **to achieve positive results**. Concerted action is needed in this area.

  2
  - Formation
  - Functioning

- **Absent or Adverse Teaming. EITHER:** There is no evidence of a formed or functional family team for this child and family with all interveners working independently and in isolation from one another. **- AND/OR -**The actions and decisions made by the group are inappropriate, adverse, and/or antithetical the guiding principles of family-centered practice and system of care integration and coordination of services across agencies for the child and family **to achieve positive results**. Concerted action is needed in this area.

  1
  - Formation
  - Functioning

- **Not applicable:** The case being reviewed is an **Assessment.**

  NA
  - Functioning (Assessments)

PRACTICE REVIEW 3: CULTURAL RECOGNITION

CULTURAL RECOGNITION: • How well have any significant cultural issues, family beliefs, and customs of the child/youth and family been identified and addressed in practice (e.g., culture of poverty, domestic violence, mental illness or incest)? • Are the natural, cultural, or community supports appropriate for this child and family being provided? • To what degree are the necessary supports and services provided being made culturally appropriate in the family engagement, assessment, planning, and service delivery processes. • To what degree are family values and beliefs recognized when developing plans for sustainable, safe case closure? Plans to address the family's maladaptive behaviors, values, and beliefs should not adversely affect the child/youth's safety, permanency, and well-being. [Last 90 Days]

"Culture" is broadly defined. Review focus is placed on whether the child and family's culture has been assessed, understood, and accommodated, when appropriate. Careful judgment is required in distinguishing the family situation to which this indicator applies. The reviewer does not have to be of the same culture as the family but does have to have necessary language skills or interpreter assistance when communicating with the family in making a determination. For example, mental illness is a culture requiring the team to assess the family's needs and then identify the appropriate accommodations needed to support the child and family in the change process.

Making appropriate cultural accommodations involves a set of strategies used by practitioners to individualize the service process to improve the goodness-of-fit between family members and providers who work together in the family change process. Many families may require simple adjustments due to differences between the family and providers. Such simple adjustments are a routine part of engagement, assessment, planning, and service provision. A family's identity may shape their world view and life goals in ways that must be understood and accommodated in practice, (e.g., religious/ spiritual affiliations, gang membership, sexual minorities, prior wardship). New immigrants, visually and hearing impaired, and homeless families all may have their own unique identities, values, beliefs, and world views that shape their ambitions and life choices. These families require use of more specialized and intensive accommodations and culturally competent supports in order to successfully engage, educate, assist, and support a family moving through a change process to family independence and sustainable, safe case closure by the system, as child welfare agencies serve an increasing proportion of children and families outside the majority culture. Recognition includes valuing cultural diversity, understanding how it impacts family functioning in a different majority culture, and adapting service processes to meet the needs of culturally diverse children and their families. Properly applied in practice, cultural recognition reduces the likelihood that matters of language, culture, custom, identity, value, or belief will prevent or reduce the effectiveness of family change efforts.

There are some components of care that have been significantly associated with positive outcomes for clients from various cultures. Essentially, respect of differences, easy accessibility to care with community and family involvement is empirically associated with positive mental health outcomes for diverse populations. Nine specific components of care are seen as critical to this process which include: (1) shared culture; (2) shared language; (3) agency located in clients' community; (4) flexible hours and appointments; (5) provision of or referral to social, economic, legal, and medical services; (6) family involvement; (7) brief interventions; (8) referral to spiritual advisors or traditional healers; and (9) involving clients in determining, evaluating, and publicizing services (Switzer, Scholle, Johnson, & Kelleher, 1998).

Determine from Informants, Observations, Plans, and Records

1. Is the family's cultural identity and related needs identified?
2. Are assessments performed appropriate for the family's background?
3. Do the service providers respect family beliefs and customs? • Where indicated, are tribal laws and customs respected and ICWA requirements met?
4. Is there a need for the FCM and service providers to be of the same cultural background as this family? • Do the FCM and service providers have adequate knowledge of cultural issues relevant to service delivery for this child and family? • If not, what is missing or misunderstood?
5. If the child or parent/caregiver has a primary language that is other than English, are translator services provided, and how is reliability of translator ensured?
6. Has the family team explored natural, cultural, or community supports appropriate for this child and family?
7. Specific cultural issues identified and addressed in this case are:
   ☐ Racial, tribal, ethnic ☐ Sexual Orientation ☐ Class, income/poverty
   ☐ Environmental ☐ Dietary ☐ Religious
   ☐ Other, such as deaf, visually impaired, military culture:
8. How does the family identify it own culture? • How has culture been assessed in this case? • What impact, if any, do any cultural differences play on engagement and team work in this case? • How sensitive to cultural issues is the FCM in this case? • Are cultural differences impeding working relationships with this child and family? • How have cultural conflicts been resolved?

Domains of Cultural Competence are:

- *Values and attitudes that promote mutual respect.*
- *Communication styles that show sensitivity and non-judgmental stance.*
- *Community and active consumer participation in developing evaluation of policies, practices, and interventions that builds on cultural understandings.*
- *Physical environment including settings, dietary needs, materials, and resources that are culturally and linguistically responsive.*
- *Policies and procedures that incorporate cultural/linguistic principles and multi-cultural practices, and locations of diverse populations.*
- *Population-based clinical practice that avoids misapplication of scientific knowledge and stereotyping groups.*
- *Training and professional development in culturally competent practice.*

Reviewers should consider the requirements of two federal laws (i.e., ICWA and MEPA), as appropriate, to the child and family under review.

PRACTICE REVIEW 3: CULTURAL RECOGNITION

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Child and Family	Rating Level

- **Optimal Cultural Understandings and Recognition.** The family's cultural identity has been assessed thoroughly and with cultural sensitivity Specialist services are provided in a culturally appropriate manner for this child and family on a consistent and reliable manner with the child and family being asked for their feedback throughout service. The child and family's cultural identity is recognized and well understood, and services are flexibly tailored to meet related needs. Family cultural beliefs and customs are fully respected and well accommodated in service processes. All assessments use culturally appropriate language that is not judgmental and limitations or potential cultural biases are recognized and noted. Service providers are fully knowledgeable about issues related to the child's identified culture and shape treatment planning and delivery appropriately by ensuring the child and family have an active voice in service planning. Other natural community helpers important to the child's culture are included in service planning and delivery. Service providers have ensured optimal cultural understanding by seeking feedback, suggestions, and meeting with community contacts who are similar or familiar to the culture of the child and family. Service delivery and planning has illustrated that interventions were designed to fit the client's cultural needs rather than requiring or demanding the client to change and fit the system. **6**

- **Good Cultural Understandings and Recognition.** The family's cultural identity is recognized and services generally address related needs. Feedback is sought from the child and family about its effectiveness. Family cultural beliefs and customs are respected and taken into consideration for planning services. Most assessments are culturally appropriate and limitations or potential cultural bias is recognized. Other natural community helpers important to the child's culture are acknowledged and information is obtained from them. **5**

- **Fair Cultural Understandings and Recognition.** The family's cultural identity is recognized and the providers acknowledge this in the assessment, planning process, and service delivery. Family cultural beliefs identity and customs are usually acknowledged and services are planned in an effort to avoid violations. For example, the provider might acknowledge and reach out to other natural community helpers important to the child's culture and works with the child and family to integrate those supports. **4**

- **Marginal Cultural Understandings and Recognition.** The family's cultural identity is recognized and the providers acknowledge that assessment, treatment planning, or services are not a good fit but is seeking to improve these processes for the child and family. There may be evidence that the families' culture is understood by the provider/agency in some cases, although it is limited or inconsistent for this child. Concerted action is needed in this area. **3**

- **Poor Cultural Understandings and Recognition.** The family's cultural identity is not recognized in the service process. Few assessments were sought that could have assisted service delivery with the child and family. There may little evidence that the family's culture is understood by the provider/agency. Concerted action is needed in this area. **2**

- **Adverse Cultural Understandings and Recognition.** There is no evidence of cultural recognition in this case. No assessments were sought that could have assisted service delivery with the child and family. There has been no attempt by service providers to understand and accommodate possible cultural needs of the child and family. The child and family's cultural identity may be treated with disrespect and their customs, values and beliefs may be ignored, stereotyped, treated as irrelevant or deemed inferior. Assessment, treatment planning, or service delivery processes do not seek to get feedback at any point in time from the child and family about their cultural beliefs and customs. Concerted action is needed in this area. **1**

PRACTICE REVIEW 4: ASSESSING & UNDERSTANDING

ASSESING & UNDERSTANDING: To what degree: • Does the team have a shared, big picture understanding of the child/youth and parent's underlying issues, needs, strengths, protective capacities, hopes, and safety risks that must change for the child to live safely and permanently with the family of origin or adoptive family without agency supervision? • Are these understandings reflected in the family change process used for helping the family achieve safety, permanency, and well-being (as defined in stated conditions for sustainable, safe case closure in the LONG-TERM VIEW)? • Is ongoing situational awareness of the child and parent being maintained throughout the child/youth and family change process? [Last 90 Days/Past 12 Months]

As appropriate to the situation, a combination of safety risk, clinical, functional capacity, and support assessments, interpretation, and synthesis techniques should be used to determine the underlying issues, needs, strengths, risks, interests, and future goals of the child and parents. Once gathered, the information should be analyzed and synthesized to form an ongoing functional assessment and big picture understanding of the child and parents. This involves understanding the CORE STORY of the family and how the family reached its present situation. This story frames the child's and parent's history, strengths, assets, needs, safety risks, functioning, and preferences within the environmental context and current social support networks. Assessment techniques, both formal and informal, should be appropriate for the child's and parent's age, capacity, culture, language or system of communication, support system, and social ecology. New assessments should be performed promptly when planned goals are met, when emergent needs or problems arise, or when changes are necessary. Ongoing assessment findings should stimulate and direct modifications in strategies, services, and supports for the child and parent. Monitoring and evaluation results should be used to update the big picture view of the child and parent to maintain situational awareness. Members of the child/family team (including family and other interveners), working together, assemble and interpret their collective KNOWLEDGE and WISDOM to form a shared big picture view that provides a common working understanding of the child and parent's situation, their underlying needs, and what must be done to reach sustainable, safe case closure. This provides a common core of intelligence for unifying efforts, planning joint strategies, sharing resources, finding what works, and achieving a good mix and match of supports and services for the child and parent. Maintaining wise understandings requires a dynamic, ongoing process to learn what works for the family.

Determine from Informants, Observations, Plans, and Records

1. How well does the FCM and team understand this child and parent? • What threats of harm and parental protective capacities are present and changing? • What will it take to reach sustainable, safe case closure? • What is working or not working now? • How is information synthesized and shared?

   - How well are strengths, supports needs, safety risks, hopes, aspirations, and preferences of the child, parent/resource parent known and understood by those involved (team)?
   - How well does the team understand what may be required for: • Safety and risk • Protective capacities and conditions • Changes in psychiatric symptoms/ maladaptive behaviors/addiction patterns • Concurrent alternatives/pathways to permanency • Sustainable supports • Resiliency/coping skills for child Recovery/relapse prevention for older youth and adults • Successful transitions and life adjustments • Resolution of permanency • Sustainable, safe case closure?

2. How well are child and parent stressors recognized? How are these matters understood within the context and culture of this child and family?

   - Earlier life traumas and disruptions
   - Maltreatment and safety risk patterns
   - Co-occurring disabling conditions
   - Problems of attachment and bonding
   - Learning/memory problems affecting school or work
   - Developmental delays or disabilities
   - Physical and/or behavioral health concerns
   - Recent life transitions and adjustments to new conditions
   - Subsistence challenges of parent and child
   - Court-ordered requirements/constraints
   - Recent tragedy, loss, victimization
   - Extraordinary parental burdens

3. On what ongoing observations, assessments, or evaluations does the team base progressive understandings of the child and parent? • Are assessments culturally appropriate and conducted in natural settings and everyday activities? • Are family tendencies toward denial and/or isolation recognized?
4. How are the child's and parent's strengths and needs linked to their daily functioning? • Are supports adequate in order for positive outcomes to be achieved? • Is the child resilient and responsive to treatment? • Is the parent learning and demonstrating new behaviors in the home necessary for effective parenting? **Are positive results being achieved?**
5. How is knowledge of child's and parent's history, strengths, needs, risks, and issues being used as the basis for understanding the family? • How has the parent's perspectives and preferences been used to facilitate understandings? • How well is the parent's recovery and relapse prevention understood by the team?
6. Do all involved with the child and parents understand what things have to change to reduce problems and achieve adequate daily functioning?
7. What is the big picture, common working understanding of this child and parent? • If persons now involved share different views of the child and parent, what would it take for them to form a common vision and the progressive understandings necessary for family change purposes?
8. In a case involving an Indian child and parent, have the laws, customs, and philosophy of the tribe been reflected in the development and implementation of the path to permanency for the child, including any concurrent goals and strategies for achieving permanency via another family?
9. In cases involving domestic violence, are the dynamics of power, control, and entitlement on the part of the perpetrator assessed and understood? • In such cases, was the assessment conducted in a manner designed to assure the safety of all family members?
10. Has the assessment and understanding process evolved as the collective result of those persons who know the child and parent best and who are, involved in the family change process? • What are the present prospects for permanency with the birth family? • Alternative family?

PRACTICE REVIEW 4: ASSESSING & UNDERSTANDING

Description and Rating of Practice Performance

NOTE: *If parental rights have been terminated, then the mother and father options would be marked NA. If the child has been adopted, the mother and father options would be scored on the adoptive parent(s).*

Thorough Assessing & Understanding Underlying Needs + LTV = Child and Family Plannning Process

A resource parent is defined as any person or people caring for a child placed outside of the family home aside from congregate care

Description of the Practice Performance Situation Observed for the Child and Parent(s) — Rating Level

- **Optimal Progressive Understandings**. Child or parent functioning, life circumstances, and support systems are comprehensively and progressively understood by those involved. Knowledge necessary to understand the child and parent's strengths, needs, and context is continuously updated and used to keep the big picture understanding relevant and comprehensive. Past maltreatment, current safety risks, parental protective capacities, behavior change requirements, family supports, and permanency resolution requirements are fully recognized and understood. Necessary conditions for child and parents functioning, family independence, sustainable, safe case closure, and permanency are fully interpreted and wisely applied to guide the family change process forward **in achieving positive results**.

6
- Child
- Mother
- Father
- Resource Parent(s)

- **Good Progressive Understandings.** Child or parent functioning, life circumstances, and support systems are generally and progressively understood by those involved. Information necessary to understand the child and parent's strengths, needs, hopes, aspirations, and context is frequently updated and used to keep the big picture understanding fresh and useful. Past Child maltreatment, current safety risks, parental protective capacities, behavior change requirements, family supports, and permanency resolution requirements are substantially recognized and well understood. Necessary conditions for child and parent functioning, family independence, sustainable, safe case closure, and permanency are generally understood and used to guide the family change process forward **in achieving positive results**.

5
- Child
- Mother
- Father
- Resource Parent(s)

- **Fairly Adequate Understandings.** Child or parent functioning, life circumstances, and support systems are at least adequately identified and periodically understood by those involved. Information necessary to understand the child and parent's strengths, needs, hopes, aspirations, and context is periodically updated and used to keep the big picture understanding somewhat useful. Some past maltreatment, current safety risks, parental protective capacities, behavior change requirements, family supports, and permanency resolution requirements are at least minimally recognized and understood by some participants. Necessary conditions for child and parent functioning, family independence, sustainable, safe case closure, and permanency are somewhat understood and used for possible change strategies **and achieving positive results**.

4
- Child
- Mother
- Father
- Resource Parent(s)

- **Marginal or Somewhat Inadequate Understandings.** Child or parent functioning, life circumstances, and support systems are marginally understood by some of those involved. Information necessary to understand the child's and parent's strengths, needs, and context is limited and occasionally updated. Past maltreatment, current safety risks, parental protective capacities, behavior change requirements, family supports, and permanency resolution requirements are partly understood on a limited or inconsistent basis by some of those involved. Necessary changes in behavior or conditions **to achieve positive results** are marginally understood by a few key participants. Concerted action is needed in this area.

3
- Child
- Mother
- Father
- Resource Parent(s)

- **Poor Understandings.** Understanding of child or parent functioning, life circumstances and support systems may be obsolete, erroneous, or inadequate. Information necessary to understand the child and parent's strengths, needs, and context is poorly or inconsistently updated. Uncertainties exist about past maltreatment, current safety risks, parental protective capacities, behavior change requirements, family supports, and permanency resolution requirements. Necessary changes in behavior or conditions **to achieve positive results** may be missing, confused, or contradictory. Dynamic conditions may be present that could require a fundamental reassessment of the child's and family's situation. Concerted action is needed in this area.

2
- Child
- Mother
- Father
- Resource Parent(s)

- **Absent, Incorrect, or Adverse Understandings.** Current assessments used for planned services are absent or incorrect. Some adverse associations between the current situation, the child functioning, and the parent's functioning and support system may have been made. Glaring uncertainties and conflicting opinions exist about things that must be changed for needs and risks to be reduced and the child to function adequately in normal daily settings. A completely new assessment would be required for this case to move forward **to achieve positive results**. Concerted action is needed in this area.

1
- Child
- Mother
- Father
- Resource Parent(s)

- **Not Applicable:** If parental rights have been terminated.

NA
- Mother
- Father
- Resource Parent(s)

PRACTICE REVIEW 5: LONG-TERM VIEW

LONG-TERM VIEW (LTV): • Is there an explicit guiding view for the child/youth and parents that should enable them to live safely and successfully without DCS supervision? • How well does the LTV define: (1) Permanency goals (primary and concurrent, if necessary) for the focus child? (2) Things that must change in the family's situation? and (3) Outcomes that must be achieved for sustainable, safe case closure? [Last 90 Days]

Where is the service team headed with this child and family? Will this direction lead to this family living together safely and successfully without formal supervision, making known transitions (e.g., move of residence, change of job) and, when necessary, reunifying family members now living away from the family home (e.g., family member returning from military assignment, resource placement, drug treatment, incarceration)? Is there a sensible guiding view for change strategies, interventions, and supports to help the family achieve independence from supervision, make any necessary transitions, or reunifications? Are clear requirements for sustainable, safe case closure specified in the case plan?

A Long-Term View (LTV) is a guiding strategic vision used to set the purpose and path of intervention and support and capacity to sustain change. It is used to focus a coherent service planning process for the family. It may be expressed as strategic goals to focus and unify service planning efforts or as conditions for sustainable, safe case closure. The LTV anticipates and defines what the family must have, know, and be able to do in order to be safe and live without continued formal supervision. Smooth and effective transitions require such a strategic vision and its fulfillment through the service process. To be useful in planning a successful family change process, the LTV must "fit" the family situation and establish a strategic course to be followed in the family change process that will lead to the achievement of the family staying safe without formal supervision. The LTV should answer the questions of where the child and family are headed in the change process and how the family and team will know when the family change process has been accomplished.

Determine from Informants, Observations, Plans, and Records

1. Is there a clear Long-Term View (LTV) for this family? • If Yes, is it explicitly written in the family's service plan?

2. Does the LTV reflect family strengths, capabilities, risks, barriers, and needs? • Does the LTV reflect the ambitions and preferences of the family?

3. What are the primary permanency and concurrent goals, if indicated, for this child? • How are these stated and addressed in the LTV?

4. If concurrent plan is utilized, is the family aware of the timelines of the concurrent plan? • Does everyone involved know what the next steps are?

5. How will the child, parent, and family team "know when they are done" with the change process being used with the child and family? • Does the LTV: (1) Clearly define what things must change for the family to live together safely without supervision? (2) Lead to good decisions about how to bring about the necessary changes?

6. What protective provisions (e.g., removal of the sexual offender, after-school supervision of youth, restraining order for a batterer) must be in place before reunification of a child to his/her family home? • What permanency issues must be resolved (e.g., termination of parental rights and approval of an adoptive family) before sustainable, safe case closure is achieved for the focus child? • What specific behavior patterns and capacities (e.g., sobriety, infant care, age-appropriate discipline of children, protection of children from an abusive parent) must be demonstrated by the parent or caregiver to show that reliable care and supervision is commensurate with that required for the safety and care of children in the home? • What sustainable supports must be present in the home and family situation (e.g., locks on cabinets to prevent poisoning of a toddler, adequate housing, daycare for a young child while the mother and/or father is at work, sufficient income to meet basic needs)? • What other legal requirements (if any) must be resolved in order to reach permanency? • Are such requirements clearly stated as conditions for sustainable, safe case closure within the LTV?

7. Does the LTV anticipate the next life changes and transitions that would need to be addressed to continue the family's progress toward meeting goals? • If the strategic goals in the LTV are met, are the child and family likely to succeed in making life adjustments after the next major transition? • If transition problems can be expected in the future, are any likely difficulties anticipated and addressed in the strategic goals set for this family?

8. Does the LTV cover functional areas for the child: living, learning, working, playing—as appropriate to the child's age and situation? • Do other agencies serving the child and family share this same LTV and does it reflect their goals, strategies, schedules, and services?

9. Will the child and family's current LTV [if implemented with necessary strategies, interventions, and supports] likely lead successfully to: (1) Family preservation, family reunification, or guardianship/adoption of the focus child? (2) Safe and sustainable conditions in the home and family situation? (3) Demonstrated and sustained improvements in parental capacities? (4) Sustainable supports for the family? and (5) Sustainable, safe case closure?

PRACTICE REVIEW 5: LONG-TERM VIEW

Description and Rating of Practice Performance

Permanency and Long-Term View (LTV) should be <u>considered together</u> when rating this indicator.
****Thorough Assessing & Understanding Underlying Needs + LTV = Child and Family Plannning Process****

Description of the Practice Performance Situation Observed for the Child and Family	Rating Level

- **Optimal Long-Term View.** The family has an explicitly written LTV that is clearly and consistently articulated among team members (family members being persons on the team). The LTV fully defines permanency and any concurrent goals for the focus child. The LTV offers a clear and highly useful guiding vision for family independence that fully reflects family strengths, capabilities, risks, barriers, needs, and preferences. The LTV fully defines what things must change in the home and family situation (e.g., protective provisions, behavioral changes, sustainable family supports, and resolution of legal matters necessary for permanency) and how the family and team will know when these changes have been achieved. The LTV fully anticipates and defines the next life changes and transitions that will be accomplished before sustainable, safe case closure. **6**

- **Good Long-Term View.** The family has a case plan narrative providing a LTV that is generally known and understood by team members. The LTV substantially describes permanency and any concurrent goals for the focus child. The LTV offers a generally useful guiding vision for family independence that substantially reflects family strengths, capabilities, risks, barriers, needs, and preferences. The LTV generally explains what things must change in the home and family situation (e.g., protective provisions, behavioral changes, sustainable family supports, and resolution of legal matters necessary for permanency) and how the family and team will know when these changes have been achieved. The LTV generally anticipates and defines the next life changes and transitions that will be accomplished before sustainable, safe case closure. **5**

- **Fairly Useful Long-Term View.** The family has a case plan narrative providing an adequately useful LTV that is somewhat known and understood by team members. The LTV adequately describes permanency and any concurrent goals for the focus child. The LTV offers a somewhat useful guiding vision for family independence that somewhat reflects family strengths, capabilities, risks, barriers, needs, and preferences. The LTV briefly explains what things must change in the home and family situation (e.g., protective provisions, behavioral changes, sustainable family supports, and resolution of legal matters necessary for permanency) and how the family and team will know when these changes have been achieved. The LTV somewhat anticipates the next life changes and transitions that will be accomplished before sustainable, safe case closure. **4**

- **Marginally Useful Long-Term View.** The family has several goals set by one or more agencies serving the child/family that create a common planning direction that is accepted and used by service team members. The LTV marginally describes permanency and any concurrent goals for the focus child. The LTV offers a limited and possibly inconsistent vision for family independence that may reflect some family strengths, capabilities, risks, barriers, needs, and preferences. The LTV marginally or somewhat inadequately explains what things must change in the home and family situation (e.g., protective provisions, behavioral changes, sustainable family supports, and resolution of legal matters necessary for permanency) and how the family and team will know when these changes have been achieved. The LTV may be somewhat vague about the next life changes and transitions that should be accomplished before sustainable, safe case closure. Concerted action is needed in this area. **3**

- **Poor or Missing Elements in Long-Term View.** The family has service plan goals set by one or more agencies serving the child/ family but that do not form a common planning direction that is accepted and used by service team members. Despite being needed, there may be no evidence of concurrent planning. The goals provide at least some simple steps or provisions that could increase the likelihood of a successful future transition but not without continued formal supervision. The LTV vaguely mentions a few things must change in the home and family situation (e.g., protective provisions, behavioral changes, sustainable family supports, and resolution of legal matters necessary for permanency). It is not clear how the family and team will know when necessary conditions have been met for sustainable, safe case closure. Concerted action is needed in this area. **2**

- **Absent or Adverse Long-Term View.** There is no common future planning direction that is accepted and used by service team members. Goals do not address requirements that would increase the likelihood of successful future transitions. - **OR** No guiding view for family change is offered that would lead to family independence and sustainable, safe case closure. Concerted action is needed in this area. **1**

PRACTICE REVIEW 6: CHILD & FAMILY PLANNING PROCESS

CHILD AND FAMILY PLANNING PROCESS: • Is the planning process individualized and relevant to needs and goals? • Are change strategies, interventions, and supports organized into a holistic and coherent service process that provides a mix of elements uniquely matched to the child/family's situation and preferences? • Does the combination of strategies, interventions, and supports fit the child/youth and family's situation so as to maximize potential results and minimize conflicts and inconveniences? [Last 90 Days]

Does this child/family have multiple plans, each developed by a separate funder or provider agency? Or, does the child/family have a single integrated plan that works as a comprehensive, dynamic service organizer that is focused by the LTV for the child and family? A cross-agency plan unifies the efforts of all interveners into a single, coherent set of purposes and processes designed to help the child become successful in school and functional in life. The child and family plan specifies the goals, roles, strategies, resources, and schedules for coordinated provision of assistance, supports, supervision, and services for the child, caregiver, and teacher. For the child to be successful at home and school, special supports may be necessary for the primary caregiver at home and for the teacher at school. Such supports should be addressed in the child and family plan, when indicated by the persons involved.

To be acceptable, a child and family plan should: (1) be based on a big picture understanding of accurate and recent assessments that explains underlying needs that must be addressed in order to bring about essential family changes; reflect the views and preferences of the child and family; (2) be directed toward the achievement of conditions necessary for family independence and sustainable, safe case closure defined in the LTV; (3) be coherent in design, prudent in the use of natural and professional resources; (4) be culturally appropriate; and (5) be modified frequently, based on changing circumstances, experience gained, and progress made. The written child and family plan is the collective intentions of the child and family team that states the path and processes of family change to be followed. This should include a written safety-plan.

Determine from Informants, Observations, Plans, and Records

1. Are strategies and services tailor-made and assembled uniquely for this child and his/her parents? • How well does the **current mix of strategies, action steps, and services** match the child/family situation, cultural background, and expressed preferences?

2. How well are change strategies, interventions, and supports matched to the family changes necessary for achieving family independence and sustainable, safe case closure?

3. Are the concurrent plans individualized to the child/ family? • Does a primary plan and concurrent plan maximize potential results and minimize conflicts?

4. Who are **the key parties involved in the planning process**? • How well are the child and family engaged and participating in planning? • How are all interveners and service providers involved in the planning?

5. Do service partners share a **common understanding and big picture view** of this child and what it will take to achieve successful results and outcomes?

6. How well does the child and family plan reflect the knowledge, preferences, and choices of those who are participating in and benefiting from service efforts?

7. Is there agreement on **the purpose, path, priority, trajectory, and end goals of intervention** among the key partners? • Are the desired short-term results and end outcomes clear to participants, agreed upon, and used to drive practice?

8. Are the roles, assigned responsibilities, commitments, and timelines clear and agreed upon by the key parties for this child? • Are there dependable working relationships among the key parties?

9. Are the support networks created around the child and family viable, sustainable, and effective in achieving short-term results?

10. To what degree is daily practice actually driven by the service planning process? • Is daily practice coherent and consistent with respect to the path, priorities, goals, and timetable of intervention for this child? • Does the case plan have a **sense of urgency** in working toward resolution and closure?

11. Are strategies and services individualized, with planning based on need and necessary strategies for change rather than on availability?

PRACTICE REVIEW 6: CHILD & FAMILY PLANNING PROCESS

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Child and Family — Rating Level

****Thorough Assessing & Understanding Underlying Needs + LTV = Child and Family Plannning Process****

- **Optimal Child and Family Planning Process.** An excellent planning process is used that is fully individualized and relevant to family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning is well-reasoned, building on accurate understandings from recent assessments and fully reflecting the LTV. Change strategies, interventions, and supports are optimally organized into a holistic and coherent service process providing a sensible combination and sequence of strategies, interventions, and supports uniquely matched to the child/family's situation and preferences. Planned strategies, interventions, and supports optimally fit the family's situation and change requirements so as to maximize potential results and prevent conflicts and inconveniences. Planning adapts immediately to changes in life circumstances and includes a viable concurrent plan. To be optimal, the plan should include an individualized and current, documented safety plan. **6**

- **Good Child and Family Planning Process.** A good and consistent planning process is used that is generally individualized and relevant to family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning is thoughtful, building on accurate understandings from recent assessments and substantially reflecting the LTV. Change strategies, interventions, and supports are well-organized into a holistic and coherent service process providing a useful combination and sequence of strategies, interventions, and supports well matched to the child/family's situation and preferences. Planned strategies, interventions, and supports substantially fit the family's situation and change requirements so as to enhance potential results and minimize conflicts and inconveniences. Planning adapts quickly to changes in life circumstances and includes an identifiable concurrent plan. To be good, the plan should include a generally individualized and current, documented safety plan. **5**

- **Fairly Acceptable Child and Family Planning Process.** An adequate to fair planning process is used that is somewhat individualized and relevant to family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning somewhat builds on basic understandings from assessments and adequately reflecting the LTV. Change strategies, interventions, and supports are somewhat organized into a useful service process providing a combination and sequence of strategies, interventions, and supports somewhat matched to the child/family's situation and preferences. Planned strategies, interventions, and supports adequately fit the family's situation and change requirements so as to support potential results and reduce conflicts and inconveniences. Planning adapts periodically to changes in life circumstances and includes a potential concurrent plan. To be fairly acceptable, the plan should include a somewhat individualized and current, written documented plan. **4**

- **Marginal or Somewhat Inadequate Child and Family Planning Process.** A limited or inconsistent planning process is used that is somewhat individualized and relevant to family needs and to family changes that must be made. Planning reflects limited understandings from assessments and marginally reflects the LTV. Change strategies, interventions, and supports are somewhat disorganized into a limited or possibly under-powered service process providing possible inconsistent or inadequate strategies, interventions, and supports somewhat mismatched to the child/family's situation and preferences. Planned strategies, interventions, and supports don't well fit the family's situation and change requirements and may limit potential results and increase conflicts and inconveniences. Planning adapts occasionally and/or inconsistently to changes in life circumstances and a concurrent plan is not fully established. The plan includes a somewhat individualized and documented safety plan but it is not current to the present circumstances. Concerted action is needed in this area. **3**

- **Poor Child and Family Planning Process.** A substantially inadequate planning process is used that is neither individualized nor relevant to family needs and to family changes that must be made. Planning reflects poor understandings from assessments and may not reflect the LTV. Change strategies, interventions, and supports are substantially disorganized, limited or possibly under-powered and may be mismatched to the child/family's situation and preferences. Poorly planned strategies, interventions, and supports may not fit the family's situation and change requirements, may fail to yield results, and may cause unnecessary conflicts and inconveniences. Planning may not adapt to changes in life circumstances and a concurrent plan has not yet been addressed with all team members. The plan includes a documented safety plan but it is neither individualized nor current to the present circumstances. Concerted action is needed in this area. **2**

- **Absent, Ambiguous, or Adverse Child and Family Planning Process.** The child and family plan works toward divergent and conflicting goals. Basic strategies, interventions, and supports may not be addressed. The fit between the child/family situation and the service mix is unacceptable and strategies, interventions, and/or supports may be woefully inadequate to meet identified needs. Child/family preferences did not influence the selection of supports and services. The planning process does not adapt to any changes in life circumstances and no concurrent plan exits. No documented safety plan exits. Concerted action is needed in this area. **1**

PRACTICE REVIEW 7: PLANNING TRANSITIONS & LIFE ADJUSTMENTS

PLANNING TRANSITIONS & LIFE ADJUSTMENTS: To what degree: • Is the current or next life change transition for the child/youth being planned, staged, and implemented to assure a timely, smooth, and successful adjustment for the child/youth and family after the change occurs? • Are transitional staging plans/arrangements being made to assure a successful transition and life adjustment in daily settings? • If the child/youth is returning home and to school following temporary placement in out-of-home care, treatment, or detention, is the transition and life adjustment sequence working? • Is there follow-along support for the adjustment period? [Last 90 Days]

NOTE: *This review applies only to a child or youth who is now transitioning through a significant life change and adjustment process (e.g., reunification with the birth family) or who will begin a major life change and adjustment process within the next three months.*

A child moves through several critical transitions over the course of childhood and adolescence (e.g., from preschool to kindergarten, from school to school or from high school to work or adult services). Some children may experience removal from their birth family for child protection or treatment reasons. Some may be reunified with the birth family, provided guardianship with kin, or adopted by another family. For children with special learning needs and problems, such transition points pose challenges that should be planned for the child/youth to be successful during and after the crossing of a new threshold. Requirements for future success have to be determined and provided currently to achieve later success. These requirements should be used in setting strategic goals and in planning services. Meeting conditions for sustainable, safe case closure often depends on smooth and successful transitions.

Well-staged across service settings and providers is essential, especially when a child is served temporarily in a setting away from his/her home and school. Transition plans, problem-solving assistance, and supports may have to be provided. Special arrangements or accommodations may be required for success in a return setting or a new setting. Continual monitoring may be required for an adjustment period. Special coordination efforts may be necessary to prevent breakdowns in services and to prevent any adverse effects transition activities may have on the child and family. To be effective, transition plans and arrangements have to produce successful transitions as determined after the change in settings actually occurs.

Determine from Informants, Observations, Plans, and Records

1. Is the child moving through a current transition and life adjustment phase? • Is the child anticipating a major transition within the next year?

2. Has the FCM identified the child's next critical transition? • If so, what transition plans are being made to accomplish a smooth transition? • Are necessary transitional and follow-along adjustment plans being thoughtfully staged, put in place with timely sequencing and supports, and used as appropriate to provide follow-along support for successful life adjustments in the child's normal daily settings (home and school) and life activities?

3. How well are the transitional and follow-along activities and events being anticipated, staged, and arranged across settings, time, providers, and funding sources? • Do permanency plans for this child or youth indicate that the agency has used or considered using trial home visits to facilitate transition and return from out-of-home care? • How is the family involved in implementing important aspects of the child's life change and adjustment and any necessary changes needed in the home and caregiving arrangements to achieve successful reintegration of the child into the life of the family?

4. If this child has a history of difficult transitions or placement changes, how is this knowledge being used to improve transitions? • If the child or family is Indian, does the plan reflect the placement preferences or other requirements of ICWA?

5. If a transition is imminent, is a well-staged transition plan or articulation process currently being implemented for this child?

6. Is this child currently experiencing adverse consequences of a recent transition or change in placement? • If so, what are the reasons, and what is being done about it?

7. For what period of time, such as 60-90 days, is the child being closely monitored following a transition in home or school? • How well are follow-along supports being used to track the child and those supporting the child through the life change and adjustment process, including the predictable "honeymoon" and near-term "crises" of adjustment that often attend the movement and life adjustment process for a child or youth?

8. Is the transition support plan sufficiently robust to cover the full scope of the child's life change effects and adjustment needs? • Is the transition and follow-along support process being implemented in a timely, continuous, and sufficient way so as to accomplish a smooth and successful life change and adjustment for the child and without risk of disruption?

9. Are there plans/arrangements for the successful transition from a primary plan and concurrent plan? • Are there plans in place to assist the child in adjustment once the transition is made?

PRACTICE REVIEW 7: PLANNING TRANSITIONS & LIFE ADJUSTMENTS

Description and Rating of Practice Performance

NOTE: *This review applies only to a child or youth who is now transitioning through a significant life change and adjustment process (e.g. reunification with the birth family) or who will begin a major life change and adjustment process within the next three months.*

Description of the System Performance Situation Observed for the Child/Youth	Rating Level
♦ **Optimal Transition Planning.** The child's current/next transition has been planned, staged, and implemented consistent with the child's planned movement and adjustment requirements. What the child should know, be able to do, and have as supports to be successful after the transition occurs is being developed now. If a transition to another setting (or return to home and school) is imminent, excellent arrangements (for supports and services) with persons in the receiving settings are being made to assure that the child is successful following the move. If the child has made a transition (or return) within the past 6 months, the child is fully stable and successful in his/her daily settings.	6
♦ **Good Transition Planning.** The child's next transition has been identified and discussed. What the child should know, be able to do, and have as supports to be successful are planned and being addressed. If a transition to another setting (or return to home and school) is imminent, good and substantial arrangements (for supports and services) with persons in the receiving settings are being made to assist the child during and after the move. If the child has made a transition (or return) within the past 3 months, the child is generally stable and successful in his/her daily settings.	5
♦ **Fairly Adequate Transition Planning.** The child's next transition has been identified. What the child should know, be able to do, and have as supports to be successful are known and being used for planning. If a transition to another setting (or return to home and school) is imminent, basic arrangements (for supports and services) with people in the receiving settings are in place to adequately assist the child during and after the move. If the child has made a transition (or return) within the past 30 days, the child is adequately stable in his/her daily settings and is not at risk of disruption due to transition and life adjustment problems.	4
♦ **Marginal Transition Planning.** The child's next transition has been identified. What the child should know, be able to do, and have as supports to be successful have not been adequately assessed and few plans have been made. If a transition to another setting (or return to home and school) is imminent, few or partial arrangements (for supports and services) with people in the receiving settings are in place to assist the child during and after the move. If the child has made a transition (or return) within the past 30 days, the child may be experiencing mild transition problems in his/her daily settings and is at low risk of disruption. Concerted action is needed in this area.	3
♦ **Poor Transition Planning.** The child's next transition has not been addressed. If a transition to another setting (or return to home and school) is imminent, no adequate arrangements (for supports and services) with people in the receiving settings are in place to assist the child during and after the move. If the child has made a transition (or return) within the past 30 days, the child may be experiencing substantial transition problems in his/her daily settings and is at moderate to high risk of disruption. Concerted action is needed in this area.	2
♦ **Adverse Transition Planning.** The child's next transition has not been considered. If a transition to another setting (or return to home and school) is imminent, arrangements (for supports and services) with people in the receiving settings are not in place to assist the child during and after the move. If the child has made a transition (or return) within the past 30 days, the child may be experiencing major transition problems in his/her daily settings and is at high risk of disruption. Concerted action is needed in this area.	1
♦ **Not Applicable.** If identification efforts reveal no evidence of needs to be addressed for transition services for this child at this time, then this review indicator is deemed **not applicable** to this child.	NA

PRACTICE REVIEW 8: INTERVENTION ADEQUACY

INTERVENTION ADEQUACY: To what degree are the change-related interventions, actions, and resources provided to the child/youth, mother, father, and resource parent(s) of sufficient power (precision, intensity, duration, fidelity, and consistency) to produce desired results and make timely progress necessary to meet sustainable, safe case closure requirements and to sustain family independence from the service system following closure? [Last 90 Days/Past 12 Months]

The purpose of intervention is bringing about successful change processes for a child and family. As necessary for the child and family, a specifically arranged combination and sequence of interventions may lead to: (1) situational stability; (2) reduction of psychiatric symptoms, maladaptive behaviors, and/or substance use; (3) planned behavioral outcomes, including adequate daily functioning in normal settings and life activities; (4) sustainable supports; (5) successful transitions and life adjustments; and (6) sustainable, safe case closure.

Driving planned intervention processes successfully to the required outcomes often requires a combination and sequence of informal supports and formal interventions to meet change requirements. Each planned change is driven by one or more specific strategies that must be put into action, resourced, and coordinated in the proper combination, sequence, duration, and intensity to **achieve the desired results**. The driving forces for specific changes must have power (i.e., appropriate strategy combination, sequence, duration, intensity, continuity, coordination, precision/fidelity in delivery, and demonstration of efficacy in change produced) commensurate with that required to bring about the desired change and to sustain that change over time to reach child/family independence. The central principle and moral imperative of practice is to find what works. The purpose of this review is determining the extent to which the combination of change strategies being used for the focus child and family demonstrates that the POWER of planned intervention is commensurate with the changes to be made for child and family success. The reviewer should consider the following elements as they combine to form the change process for the child and family.

1. **What is required in powerful interventions may include, when available and indicated, the use of evidence-based practice strategies and related fidelity criteria for measures applied to ensure adequate implementation for desired effect.**
   - Level of intensity, duration, coordination, and continuity are implemented to produce the changes necessary for child and family with sustained success leading to family independence, successful transitions, and sustainable, safe case closure. This consideration should be based on what is required for successful and sustained change, without regard for service authorizations or present availability.
   - Demonstration of progress toward attainment of conditions for sustainable, safe case closure is a test of intervention power. Adequacy of intervention power must be considered in light of its effectiveness in driving the change process in the desired direction toward attainment of conditions for sustainable, safe case closure. Lack of progress suggests that planned strategies are either the wrong strategies or that the right strategies are underpowered.
2. **What is required in powerful interventions involves inviting providers "into the team" rather than just referring the child, family, or resource parent(s) "out" for services to a provider who is not connected with the team and who may not fully understand the family situation.**
   - Including providers on the team provides the opportunity to discuss, select, try out and, when necessary, to replace strategies, so that interventions and supports being used have the best chances of actually working for the child, family, and resource parent(s).
   - Inviting providers into the team is useful for integrating intervention efforts, measuring effectiveness of strategies, and making timely and successful adjustments.

Determine from Informants, Observations, Plans, and Records

1. What are the specific strategies being used in the change process for this child and family? • What is required for precise delivery (for desired effect) of each strategy? • How well are preparation and supports for placements working for this child, parents, and/or resource parent(s)?
2. Is the level of intensity, duration, coordination, and continuity consistent with what is required for successful and sustained child/family change? • If not, are current service authorization rules or limitations leading to discontinuity or inadequacy of effect? • Do the strategies match the changes to be made in this case? • If not, what is missing?
3. Are service providers in this case adequately trained, prepared, coordinated? • How well are clinical, instructional/vocational, supportive, and protective interventions being implemented?
4. Are any and all urgent needs met in ways that protect the health and safety of the child or, where necessary, protect others from the child?
5. Are there any change strategies for the child/parents/resource parents that cannot be adequately addressed with precision, resourced, coordinated, or delivered with continuity? • If yes, what and why?
6. How well is daily practice driven by the family team planning process in this case?
7. Are interventions being offered for both a primary plan and concurrent plan?

PRACTICE REVIEW 8: INTERVENTION ADEQUACY

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Child, Parents and Resource Parent(s) — Rating Level

- **Optimal Intervention.** An excellent combination, sequence, and power of current interventions is helping the child and family reach optimal levels of functioning necessary for them to make progress and live together successfully. An excellent combination of informal and, where necessary, formal supports and interventions is provided with excellent precision and with fully commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is fully sufficient to quickly and fully reach or exceed all of the outcomes and ending requirements necessary for this child and family to achieve functional independence, successful transitions, and sustainable, safe case closure.

6
- Child
- Mother
- Father
- Resource Parent(s)

- **Good Intervention.** A good combination, sequence, and power of current interventions is helping the child, and family reach good and substantial levels of functioning necessary for them to make progress and live together successfully. A dependable combination of informal and, where necessary, formal supports and interventions is provided with good precision and with substantially commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is generally sufficient to reach most of the outcomes and ending requirements necessary for this child and family to achieve functional independence, successful transitions, and sustainable, safe case closure.

5
- Child
- Mother
- Father
- Resource Parent(s)

- **Fairly Adequate Intervention.** A fair combination, sequence, and power of current interventions is somewhat helping the child and family reach adequate to fair levels of functioning necessary for them to make progress and live together successfully. An adequate combination of informal and, where necessary, formal supports and interventions is provided with some precision and with at least adequate levels of intensity, duration, continuity, and coordination. The power of intervention is adequate to reach some of the outcomes and ending requirements necessary for this child and family to achieve functional independence, successful transitions, and sustainable, safe case closure.

4
- Child
- Mother
- Father
- Resource Parent(s)

- **Marginally Inadequate Intervention.** A somewhat underpowered combination and sequence of current interventions is helping the child and family reach somewhat inadequate or inconsistent levels of functioning necessary for them to make progress and live together successfully. A marginal combination of informal and, where necessary, formal supports and intensity, duration, continuity, and coordination. The power of intervention is not sufficient to reach some of the most important outcomes and ending requirements necessary for this child and family to achieve functional independence, successful transitions, and safe case-closure. Concerted action is needed in this area.

3
- Child
- Mother
- Father
- Resource Parent(s)

- **Poor Intervention.** A very limited combination, sequence, and power of current interventions is not helping the child and family reach levels of functioning necessary for them to make progress and live together successfully. A poor and insufficient combination of informal or formal supports and interventions is provided without precision and without adequate levels of intensity, duration, continuity, and coordination. The power of intervention is not adequate to reach many of the outcomes and ending requirements necessary for this child and family to achieve functional independence, successful transitions, and sustainable, safe case closure. Concerted action is needed in this area.

2
- Child
- Mother
- Father
- Resource Parent(s)

- **Absent or Adverse Intervention. EITHER:** (1) Currently planned interventions are not implemented. **- OR -** (2) The wrong interventions are being implemented without desired effect and/or with adverse effects. **- OR -** (3) Potentially successful interventions are provided but are underpowered to achieve desired effects and outcomes. Concerted action is needed in this area.

1
- Child
- Mother
- Father
- Resource Parent(s)

- **Not Applicable.** If parental rights have been terminated or the child/youth is not residing in a resource home

NA
- Mother
- Father
- Resource Parent(s)

PRACTICE REVIEW 9: RESOURCE AVAILABILITY

RESOURCE AVAILABILITY: To what degree are formal supports, services, and resources necessary to implement planned change strategies available as required (i.e., timeliness, fit to the situation, and change strategy used, intensity, duration, locally accessible) for use by the: (1) focus child, (2) the parent(s), and (3) the caregiver(s) in meeting family change requirements and conditions for sustainable, safe case closure (and beyond)? [Last 90 Days]

An adequate array of supports and services is necessary to implement intervention and support strategies for the focus child, parent, and caregiver. To respond to unique needs, supports may have to be created or assembled in special arrangements. Such services include wraparound services* for a special need child in his/her home or school setting so as to avoid placement in more restrictive settings away from home and school. Some formal services may be allocated by units (e.g., six units of therapy) while others may be placement-based (e.g., residential treatment). Formal, paid supports can range from reading tutors to after-school supervision, adult mentors, recreational activities, and supported employment. Supports may be provided by agency staff or purchased from provider organizations. Professional treatment services may be offered through health care plans or funded by government agencies. A combination and sequence of supports and services may be necessary to support and assist the child, parent, and caregiver.

For interveners to exercise professional judgment and for the family to exercise choice in the selection of intervention/change services and supports, an array of appropriate alternatives should be locally available. Such alternatives should present a variety of socially or therapeutically appropriate options that are readily accessible, have power to produce desired changes, be available for use as needed, and be culturally compatible with the needs and values of the family. An adequate array of services includes social, health, mental health, educational, vocational, recreational, housing, income maintenance, and organizational services, such as service coordination. An adequate array spans supports and services from all sources that may be needed by the focus child, parents, and caregivers. Selection of basic supports should begin with family network supports and generic community resources available to all citizens. Specialized and tailor-made supports and services should be developed or purchased only when necessary to supplement rather than supplant readily available supports and services of a satisfactory nature. Unavailable resources should be systematically identified to enable the network to meet the need.

Determine from Informants, Observations, Plans, and Records

1. Is each change strategy set for the focus child, parents, and caregiver matched with the resources necessary for its accomplishment? • Are resources matched to change strategies addressed in various agency's plans? • Are these resources available as needed by the child, parent, and caregiver to meet change requirements on schedule?
2. To what extent are community resources including; extended family, neighborhood, civic clubs, churches, charitable organizations, local businesses, and general public services (e.g., recreation, public library, or transportation) used in providing supports for this family?
3. Is each support provided socially and culturally appropriate for the family?
4. Is the service team taking steps to locate or develop or advocate for previously unknown or undeveloped resources?
5. Did members of the family's service team have appropriate service options from which to choose when recommending professional services?
6. Did the family have appropriate and preferred options from which to choose when selecting supports and services?
7. Is each intervention service therapeutically appropriate for the child and family?
8. Is each service and support readily accessible when needed? • If not, what is missing?
9. Were any of the supports and services tailor-made or assembled uniquely for this child or family? • Are they sustainable as needed over time?
10. Are formal supports and services being used sufficiently for the child, parents, and caregiver to meet change requirements?

**NOTE:*

Use of wraparound services may be necessary to prevent placement by increasing the range and intensity of services in a child's home or school - OR - to return a child from residential treatment to his/her home and school successfully. Such use may require blending of funding across sources and blending of agency traditions that would limit or prevent success in individual case situations.

If a placement is being used or continued when "wrap-around" services would likely be successful in keeping a child in home and school or in returning a child to home and school, then availability of flexible, wrap-around resources may be inadequate to meet the child's current needs.

PRACTICE REVIEW 9: RESOURCE AVAILABILITY

Description and Rating of System Performance

Description of the System Performance Situation Observed for the Child and Family	Rating Level

- **Optimal Resource Availability.** An excellent array of high quality formal services and resources necessary to implement planned change strategies are fully and continuously available as required (i.e., always timely; excellent fit to the situation and change strategy used; fully sufficient in intensity, duration, and dependability; in fully convenient, accessible locations) for use by the child, the parents, and/or the caregiver(s) in meeting change requirements and conditions for sustainable, safe case closure. The array provides a wide range of options for use of professional judgment about appropriate interventions and for family choices of providers. **6**

- **Good Resource Availability.** A substantial array of good quality formal services and resources necessary to implement planned change strategies are generally available as required (i.e., usually timely; good fit to the situation and change strategy used; generally sufficient in intensity, duration, and dependability; in generally convenient, accessible locations) for use by the child, the parent, and/or caregivers in meeting change requirements and conditions for sustainable, safe case closure. The array provides a good range of options for use of professional judgment about appropriate interventions and for family choices of providers. **5**

- **Fair Resource Availability.** An adequate array of fair quality formal services and resources to implement planned change strategies are adequately available as required (i.e., sometimes timely; fair fit to the situation and change strategy used; adequately sufficient in intensity, duration, and dependability; in fairly convenient, accessible locations) for use by the child, the parents, and/or caregivers in meeting change requirements and conditions for sustainable, safe case closure. The array provides adequate options for use of professional judgment about interventions and some family choices of providers. **4**

- **Marginal Resource Availability.** A somewhat limited, inadequate, or inflexible array of formal services and resources necessary to implement planned change strategies are only marginally or inconsistently available (i.e., sometimes delayed; limited in fitting the situation and change strategy used; limited or inconsistent in intensity, duration, and dependability; sometimes inconvenient or inaccessible locations) for use by the child, the parents, and/or the caregivers, thus, limiting the attainment of change requirements and conditions for sustainable, safe case closure. The array provides few options for use of professional judgment about interventions or family choices of providers. Concerted action is needed in this area. **3**

- **Poor Resource Availability.** Only scattered, inconsistent, or inadequate formal services and resources necessary to implement planned change strategies are available (i.e., often delayed or missing; poor fit to the situation and change strategy used; inadequate in intensity, duration, or dependability; often in inconvenient or inaccessible locations) for use by the child, the parents, and/or caregivers, thus, limiting or preventing the attainment of change requirements and conditions for sustainable, safe case closure. No options for use of professional judgment about interventions or family choices of providers may exist. Concerted action is needed in this area. **2**

- **Absent or Adverse Resource Availability.** Few, if any, formal services and resources are provided at this time. They may not fit the actual needs of the family well, and may not be dependable over time. Some services of poor quality or inappropriate fit may be causing unintended problems or adverse effects. Due to supports not being well developed and local services or funding being limited, any services may be offered on a "take it or leave it" basis. The family may be dissatisfied with or refuse services and results may present a potential safety risk to the focus child, parents, or caregivers. The service team may be powerless to alter the service availability situation or the child and family may lack a functioning service team. Concerted action is needed in this area. **1**

PRACTICE REVIEW 11: TRACKING & ADJUSTING

TRACKING & ADJUSTING: • Does the team monitor the child/youth and family's progress, intervention process, and make the necessary adjustments? • Are strategies and services modified to respond to the changing needs and to apply knowledge gained about planned strategies and results to create a self-correcting service process for finding what works for the child/youth and family? [Last 90 Days]

An ongoing examination process should be used by the family team to track service implementation, check progress, identify emergent needs and problems, and modify services in a timely manner. Tracking and adjustment provide necessary learning and change processes that make the intervention process "smart" and, ultimately, effective for the child and family. The intervention strategies should be modified when outcomes are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The team for the child and family should play a central role in monitoring and modifying planned strategies, services, supports, and results. Team members should apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services. This learning and change process is necessary to find what works for the child and family. **Learning "what works" is a continuing process**. How are the child and family doing? Has their situation changed? Have new needs emerged? Are supports and services being delivered as planned? Are providers dependable? How well are the mix, match, and sequence of supports and services working? How well do these arrangements actually fit the needs of the child and family? Are any crisis/safety response capabilities working when needed? Are advance arrangements for transitions being accomplished? Are desired results being produced? What things need changing?

Determine from Informants, Observations, Plans, and Records

1. How well are the status and progress of the child and family being tracked and adjusted by the team in the following areas?
   a. Ongoing assessment to determine if impending danger threats to child safety have reemerged?
   b. When a child is unsafe, is the team tracking and evaluating the attainment of parents/caregivers(s) protective capacities?
   c. Attainment of protective capacities and conditions for safety and situational stability?
   d. Development and demonstration of required child and/or parent behavior changes?
   e. Securing of adequate and sustainable supports necessary for child and family functioning?
   f. Concurrent plan and alternative strategies for attaining permanency?
   g. Meeting any special needs of people (children and parents) in the home?
   h. Achieving successful transitions and life adjustments?
   i. Resolving any outstanding legal issues necessary for sustainable, safe case closure?

NOTE:

- *EFFECTIVE TRACKING requires Maintaining ongoing SITUATIONAL AWARENESS.*
- *EFFECTIVE ADJUSTMENTS depends upon the team UNDERSTANDING and ACTING on what is working and not working in helping the family meet conditions for safe case closure.*

2. How are progress and child well-being monitored by the team (e.g., face-to-face contacts, telephone contact, and meetings with family, child, service providers, reviewing reports from providers, etc.)? • Is adequate awareness of family circumstances and changes being maintained?

3. Is the implementation of planned supports and services being tracked? • Is progress or lack of progress being identified and noted?

4. Are detected problems or breakdowns in service design or delivery being reported and addressed promptly by the child and family team?

5. Are identified needs and problems being acted on? • Is the family plan modified by the team as things change, to keep the plan relevant and effective?

6. Are the case plan strategies modified as goals are met? • Are these strategies being used modified if no progress is observed? • Are failed strategies promptly recognized and abandoned and then quickly replaced with those strategies next most likely to work? • If not, why not?

7. Is there a clear and consistent pattern of successful service changes that have been made in response to use of short-term results?

8. Is the child and family change process modified as goals are met? • Is the record updated if no progress is observed? • If not, why not? • How does the team update and modify the child and family records? • How well are transitions anticipated, staged, tracked, problem-solved, and sustained?

9. Is the court advised of permanency progress in a timely fashion? • Are any requests to revise court orders pursued in a timely manner?

10. How well is the family team really finding what works for this child and family? • Are results driving the decision-making process used to guide family change to reach the planned outcomes for sustainable, safe case closure?

11. Is the progress of a primary plan and concurrent plan being monitored? • Is the team aware of when a concurrent plan will become the primary plan?

PRACTICE REVIEW 11: TRACKING & ADJUSTING

Description and Rating of Practice Performance

NOTE: *• EFFECTIVE TRACKING requires maintaining ongoing SITUATIONAL AWARENESS. • EFFECTIVE ADJUSTMENTS depends upon UNDERSTANDING and ACTING on what is working and not working in helping the family meet conditions for safe case closure.*

Description of the Practice Performance Situation Observed for the Child/Youth and Family	Rating Level
♦ **Optimal Tracking and Adjustment Processes**. The strategies, supports, and services being provided to the child and family are highly responsive and fully appropriate to changing conditions. Continuous monitoring, tracking, and communication of child's status and service results to the child and family team are occurring. Timely and appropriate adaptations are being made. Highly successful modifications are based on a rich knowledge of what things are working and not working for the child and family **in achieving positive outcomes**.	**6**
♦ **Substantially Effective Tracking and Adjustment Processes**. The strategies, supports, and services being provided to the child and family are substantially responsive to changing conditions. Frequent monitoring, tracking, and communication of child's status and service results are occurring. Generally successful adaptations are based on a basic knowledge of what things are working and not working for the child and family **in achieving positive outcomes**.	**5**
♦ **Fairly Effective Tracking and Adjustment Processes**. The strategies, supports, and services being provided to the child and family are adequately responsive to changing conditions. Periodic monitoring, tracking, and communication of child's status and service results are occurring. Usually successful adaptations to supports and services are being made which result **in achieving positive outcomes**.	**4**
♦ **Marginally Ineffective Tracking and Adjustment Processes**. The strategies, supports, and services being provided to the child and family are partially responsive to changing conditions. Occasional monitoring and communication of child's status and service results is occurring. Partially successful adaptations may be based on isolated facts of what is happening to the child and family. Their status may be adequate in some areas but unacceptable in others. The child or family could be at low risk of harm or **poor outcomes**. Concerted action is needed in this area.	**3**
♦ **Poor and Ineffective Tracking and Adjustment Processes**. Poor strategies, supports, and services are provided to the child and family and are not always responsive to changing conditions. Limited monitoring, poor communications, and/ or an inadequate child and family team are often unable to function effectively in planning, providing, monitoring, or adapting services. Few sensible modifications may be planned or implemented. Child and family status may be marginal or poor in several areas. The child or family may be at moderate to high risk of harm or **poor outcomes**. Concerted action is needed in this area.	**2**
♦ **Absent, Adverse, or Ineffective Tracking and Adjustment Process**. Strategies, supports, and services are limited, undependable, or conflicting for the child and family. Little or no monitoring or communications may be occurring and/or an inadequate child and family team is unable to function effectively in planning, providing, monitoring, or adapting services. Current supports and services may have become non-responsive to the current needs of the child and family. The service process appears to be "out of control." Child and family status may be generally poor and possibly worsening. The child or family may be at high risk of harm or **poor outcomes**. Concerted action is needed in this area.	**1**

PRACTICE REVIEW 10: MAINTAINING QUALITY FAMILY RELATIONSHIPS

MAINTAINING RELATIONSHIPS: • When children/youth and family members are living temporarily away from one another, how well are specifically planned strategies and supports working to build and sustain family connections through appropriate visits and other means, unless compelling reasons exist for keeping them apart? • To what degree have strategies and efforts been put into place to support the following between the child/youth and his/her parents for: (1) Building and maintaining positive interactions? (2) Creating and using opportunities for providing emotional support? (3) Using varied and creative opportunities for family members to nurture one another? [Last 90 Days]

NOTE: *This review* ***applies to children in out-of-home care that are living apart from their parents and/or siblings*** *for reasons of family safety.* ***Clarifications****: If the child is residing with a parent or termination of parental rights has been filed, then NA would be marked on all options. If termination of parental rights has been filed and the child has a sibling that remains a ward and they are living apart, then the sibling option would be scored. When a parent is incarcerated, scoring refine/maintain may be considered when there is ongoing contact through phone or written correspondence. Language about court orders should be in the justifications.*

This indicator addresses the quality of relationships among family members, siblings, and the relationship of the child and his/her parent(s). The quality of one's relationship with another depends on opportunities for positive interactions, emotionally supportive and mutually beneficial connections, and engaging in nurturing exchanges with one another. In families where a child is temporarily placed out of the home, the importance of and challenges encountered in maintaining and advancing the quality of relationships among family members is heightened. When child safety can be assured, a positive, emotionally supportive relationship between family members aids in preserving families and promotes successful reunification of the child with the family.

When children are living away from their parents and/or their siblings for reasons of family member safety, specialized treatment, or detention, family members should have frequent and appropriate opportunities to visit in order to maintain or develop family ties. Unless specific circumstances suggest it is unsafe or inappropriate, **visits and other forms of contact should be provided** for family members, potentially including mothers, fathers, siblings, and extended families. Such visits should be conducted in locations conducive to family activities and offer "quality time" for advancing or maintaining relationships among family members. For family members expected to live together again in the future, carefully increased or graduated visits, from short, supervised visits in safe locations to overnight or weekend visits in homes may be used to maintain, develop, or strengthen family connections. When family members are expected to continue living apart, **visits and/or other techniques such as phone calls, letters, and/or exchange of photos should be used** to enable siblings, extended family, and/or parents (if some level of contact can be safe and appropriate) to continue their family ties.

Determine from Informants, Observations, Plans, and Records

1. Have important family relationships been identified and strategies planned to maintain/strengthen them? • Are family visits occurring now? • If so:
   - How frequently are visits occurring?
   - Who coordinated and arranged the visits?
   - Are visitation settings conducive to "quality time" in relationship building?
   - Are visits increasing in frequency and duration?
   - Are visits therapeutically appropriate?
   - Are visits supervised? If so, by whom?
   - Are missed visits rescheduled in a timely manner?
   - If appropriate, is the level of supervision decreasing over time?
2. Are other forms of family contact or connecting strategies being used (e.g., phone calls, letters, and family photos)? • Is there an effort to integrate the parents into the child's life (e.g., doctor's appointments, teacher conferences at school)? • How were family members involved in making plans?
3. Are there any compelling therapeutic or legal reasons that family members should not visit with one another? • If so, what are those reasons? • Has any family member been formally/legally excluded? • If so, who, and was the suspension court approved/documented?
4. For those who are visiting, are visits being conducted at times that are convenient for the appropriate family members to get together without hardship for some members? • What supports are being provided to parents, caregiver(s) (e.g., transportation), and case managers (e.g., overtime or flextime for supervised visits) to facilitate visits? • How well do caregiver(s) and congregate care settings understand and support maintaining family connections?
5. Are family visits being used to assess the readiness of the family for reunification? • If so, what are the results and how are the visits being assessed?
6. Have opportunities been made available to encourage the parent's participation in child related activities, (e.g., school conferences, doctor's appointments, sports events)? • Have therapeutic opportunities been made available to promote the parent-child bond and to strengthen the emotional ties between the parent and the child?
7. Does the agency make use of local resources, including the placement provider if the child is in out-of-home care, to encourage nurturing responses from the parent with the child?
8. Do the parents and the child describe one another in positive terms and identify ways in which they have been able to enhance the quality of their relationship with one another?

PRACTICE REVIEW 10: MAINTAINING QUALITY FAMILY RELATIONSHIPS

Description and Rating of Practice Performance

NOTE: *This review* ***applies to children in out-of-home care that are living apart from their parents and/or siblings*** *for reasons of family safety.* ***Clarifications:*** *If termination of parental rights has been filed, then the appropriate parent rating options are marked NA; however, if the r Judge rules that visits must continue for the parents, then the appropriate indicator would be scored. If termination of parental rights has been filed, the child has a sibling that remains a ward and they are living apart, then the sibling option would be scored. When a parent is incarcerated, scoring refine/maintain may be considered when there is ongoing contact through phone or written correspondence. Language about court orders should be in the justifications.*

Description of the Status Situation Observed for the Child	Rating Level
♦ **Optimal Maintenance of Family Relationships.** Fully effective family connections are being excellently maintained for all family members through appropriate visits and other connecting strategies. All appropriate family members have regular and, where appropriate, increasingly frequent visits. Excellent, effective strategies and efforts are supporting the following opportunities between the child and his/her parents for: (1) Building and maintaining positive interactions; (2) Creating and using opportunities for providing emotional support; and (3) Using varied and creative opportunities for family members to nurture one another.	**6** ■ Mother ■ Father ■ Siblings ■ Extended family
♦ **Good and Substantial Maintenance of Family Relationships.** Generally effective family connections are being substantially well maintained for all family members through appropriate visits and other connecting strategies. All appropriate family members have regular visits. Good, generally effective strategies and efforts are supporting the following opportunities between the child and his/her parents for: (1) Building and maintaining positive interactions; (2) Creating and using opportunities for providing emotional support; and (3) Using varied and creative opportunities for family members to nurture one another.	**5** ■ Mother ■ Father ■ Siblings ■ Extended family
♦ **Fairly Adequate Maintenance of Family Relationships.** Fairly effective family connections are being at least adequately maintained for all family members through appropriate visits and other connecting strategies. All appropriate family members have periodic visits (biweekly). Adequate to fairly effective strategies and efforts are supporting the following opportunities between the child and his/her parents for: (1) Building and maintaining positive interactions; (2) Creating and using opportunities for providing emotional support; and (3) Using varied and creative opportunities for family members to nurture one another.	**4** ■ Mother ■ Father ■ Siblings ■ Extended family
♦ **Marginal, Limited, or Inconsistent Maintenance of Family Relationships.** Family connections are being at least marginally maintained for most family members through visits and other connecting strategies. Some appropriate family members have periodic visits (may be scheduled, but occurring less than biweekly). Some members may have limited, inconsistent, or infrequent contact or connections. Inconsistent and/or somewhat inadequate strategies and efforts are limiting the following opportunities between the child and his/her parents for: (1) Building and maintaining positive interactions; (2) Creating and using opportunities for providing emotional support; and (3) Using varied and creative opportunities for family members to nurture one another. Concerted action is needed in this area.	**3** ■ Mother ■ Father ■ Siblings ■ Extended family
♦ **Poor Maintenance of Family Relationships.** Family connections are being inconsistently maintained for some or most family members through visits and other connecting strategies. Some appropriate family members have occasional visits. Some members may have very limited, inconsistent, or no contact or connections. Other important family members may be substantially disconnected from the family. Substantially inadequate strategies and efforts are limiting the following opportunities ties between the child and his/her parents for: (1) Building and maintaining positive interactions; (2) Creating and using opportunities for providing emotional support; and (3) Using varied and creative opportunities for family members to nurture one another. Concerted action is needed in this area.	**2** ■ Mother ■ Father ■ Siblings ■ Extended family
♦ **Absent, Fragmented, Declining in Quality or Frequency, or Inappropriate Family Relationships.** Family connections are either fragmented, declining in frequency or quality, or inappropriate for family members. Appropriate and necessary visits are not occurring with sufficiency to maintain family connections. Some visits may be therapeutically inappropriate or unsafe for one or more family members. Concerted action is needed in this area	**1** ■ Mother ■ Father ■ Siblings ■ Extended family
♦ **Not Applicable. EITHER:** Family members are living together at home. **- OR -** Parental rights have been filed. – **OR** – Presenting circumstances prevent visits and maintenances of family connections (e.g. court order/no contact orders). Therefore, this review item is deemed not applicable in this case.	**NA** ■ Mother ■ Father ■ Siblings ■ Extended family

SECTION 5

OVERALL RATINGS

Overall Ratings of Interest **Page**

OVERALL CHILD/YOUTH & PARENT/CAREGIVER(S) RATINGS

There are nine child/youth status indicators and two parent/caregiver status indicators with sub-elements to be conducted in the areas of Child/youth Status and Parent/Caregiver Status. Each review produces a finding reported on a 6-point rating scale. An "overall rating" for each section is based on the applicable indicators.

The reviewer should consider the unique issues and context for THIS CHILD & FAMILY to arrive at the two overall status ratings.

1. Begin by transferring the rating value for each status review item from the QSR Reviewer Workbook to the Roll-Up Sheet being prepared for submission.

2. Disregard any indicators deemed not applicable

3. If the child's safety score is in the concerted action needed area (1, 2, 3), then the Overall Child status rating would be equal to the safety score.

4. Give weight to **stability and permanency** when they score in concerted action needed and all other indicators are in the refine/ maintain area.

5. Mark the boxes indicating your overall ratings on the Roll-Up Sheet.

OVERALL SYSTEM PERFORMANCE RATINGS

OVERALL SYSTEM/PRACTICE PERFORMANCE SCORING PROCEDURE

There are 11 indicators in the area of System/Practice Performance. Each review produces a finding reported on a 6-point rating scale. An "overall rating" of practice performance is based on all applicable indicators on the appropriate execution of practice functions and in response to the child and family. Consider the fidelity with which each practice function is carried out and whether the intent of the function is being achieved. Overall, is the system taking the necessary actions to appropriately address the individual factors for this child/youth and family that must be addressed if this child and family are to make progress toward behavioral change and sustainable, sustainable, safe case closure?

1. Begin examining the range and distribution of rating values for the system review indicators on the Roll-Up Sheet being prepared for submission.

2. Disregard any indicators deemed not applicable.

3. **Give weight** to those items judged to be **most important in practice** at this time for this child and family.

4. Mark the box indicating your OVERALL SYSTEM PERFORMANCE on the Roll-Up Sheet prepared for this child and family.

SECTION 6

REPORTING OUTLINES

QSR REVIEWER WORKBOOK

OVERVIEW ON COMPLETING THE REVIEWER WORKBOOK

I. DEMOGRAPHICS. Complete page 1 with all demographic information.

- Region
- County
- Case Type
- Focus Child's Full Name
- Focus Child's Age
- Mentor Reviewer
- Reviewer(s)-In-Training
- Date of Review
- Type of Placement
- Permanency Plan
- Concurrent Plan
- Safety Concerns
- Parent's Previous Ward Status

II. SCORING. For each indicator, provide a detailed description of what is both favorable and unfavorable. Remember to use strengths based language. Explain the factors contributing to favorable status and progress; (e.g. child resiliency, family capacities, or informal supports). Also describe any conditions that seem to be contributing to unfavorable status or progress. Explain how the child/youth and/or family may be adversely affected now or in the near term if status is not improved. Case examples and quotes are strongly encouraged to support each score. If the score is a 6, then there may not be any comments in the unfavorable. If the score is a 1, then there may not be any comments in the favorable section. However, all other scores should have comments in both sections, particularly scores of 3 or 4.

- **Example: Scenario where safety scored a 4.**
  Favorable: Everyone interviewed felt the child/youth was safe in his resource home and community. The caregiver(s) provide a structured environment with appropriate consequences if the child doesn't follow the rules. For example, he was recently grounded for not having good grades at school. The caregiver(s) keep in constant touch with the school and ensure the child has appropriate supervision when playing in the neighborhood.

  Unfavorable: In the last 30 days, the child has been bullied on several occasions. The caregiver(s) and the school have communicated with each other regarding the situation; however, no formal plan has been made to ensure his safety at school.

III. NEXT STEPS.

- **STRENGTHS:** Identify the strengths identified while interviewing key informants.

- **OPPORTUNITIES:** Identify the opportunities for improvement identified while interviewing key informants.

- **NEXT STEPS:** Provide 1-2 suggestions that team may want to consider taking in order to move the family toward sustainable, safe case closure. Remember: Frame your comments as suggestions, not directives.

SECTION 7

CLARIFICATIONS

ASSESSMENT CLARIFICATIONS

To get a complete understanding of the Assessment and its dynamics the entire file should be reviewed. Score the Assessment Phase of the case which is from the point of the initial call to supervisory approval date. Score the Assessment worker's actions only.

Indicators for Child/Youth Status

- Safety Indicators

  - **Safety:** Assess (during the Assessment phase) the quality of Safety for the child in all settings: Is the child free from known and manageable risks of harm? What is the caregiver's protective capacities and abilities to ensure the child's safety? Is there unresolved Domestic Violence or untreated Mental Health issues that put the child in harm's way? Is there a written Safety Plan or Family Support/Community Services Plan in place to address the Substantiation reason? Are caregivers, community supports, and child aware of and adhering to the Plan? *If a current safety risk exists, file a 310 with the county and notify the appropriate PQI team member and the FCM/FCM Supervisor. This should not be taken into consideration when scoring this section.*

  - **Behavioral Risk to Self/Others:** Does the Safety Plan protect the child or others from behavioral risk? If there is a behavioral risk to self/others, is there a Safety Plan to address the safety risk?

- Permanency Indicators

  - **Stability:** Assess CPS history in past 12 months and management of known risks in the next 6 months to achieve stability and reduce the probability of re-involvement/continuation with DCS. Over time, what is the impact of stability on the family? CPS intervention with the family should clearly indicate where ongoing case management needs to start working with the family. *Scoring guidance: If a child/youth has been removed within the past six months, a score above 3 on stability would be difficult. However, in some situations, the case could score higher. Example: A child who goes to live with a family member who has been in a close or caretaking relationship with them could score higher.*

  - **Permanency:** Was the assessment outcome appropriate given the circumstances? Is the child living in a safe, secure, appropriate, and permanent home? Are the necessary supports and Safety Plan or Family Support/Community Service Plan in place? Have the parents/caregiver(s) and support system made informed decisions for reunification, guardianship, or the use of concurrent planning to occur: commitment to raise the child to age of maturity, clear understanding of legal aspects of permanency plan, family roles defined for caregiver(s), child and support system and contact and responsibilities of members of support system. Safety, stability and adequate caregiver functioning are conditions of permanency. Would the permanency plan endure until the child attains adulthood?

Indicators of Practice Performance

- Engaging

  - **Role & Voice of Family Members:** Assess the Role and Voice of the family during the assessment phase. Did the family have input in the development of the Safety Plan or Family Support/Community Service Plan? Did the family have ownership and an understanding of the Plan? Did the family feel like they were heard? Was the family's ability to voice their strengths, protective capacities, needs, challenges and preferences heard? Were the family's immediate priorities and goals heard? Did the family have an understanding of the substantiation decision and their right to appeal the decision? If the child was removed from their home, did the family have an opportunity to suggest a placement? Was there family input, regarding issues of importance in the care of the child, (i.e., favorite foods, people who are important to them or contacts that are questionable, medical issues, routines, special items to take with them) heard?

- Teaming

  - **Team Formation:** Was a Child and Family Team Meeting (CFTM) introduced, prepped or completed during the Assessment phase? Were individuals who provide supports and/or services to the family identified as possible team members? If a CFTM was held, were the participants aware and able to identify the strengths, protective capacities, needs, challenges, preferences and Plan of the child/youth and family? Was the case transitioned from assessment worker to ongoing worker through a CFTM? *Effective Team Functioning develops over time with multiple team meetings; therefore, **Team Functioning should be scored as N/A** during the Assessment phase.*

- Assessing

  - **Assessing & Understanding:** Was the CANS, other assessments, and/or Family Functional Assessment used to assess the family? Did the assessment include risks and needs beyond the specific issue raised in the referral? Were the underlying needs of the family identified and were they addressed during the Assessment phase? Did the FCM weigh the Risks and Strengths of the family to assess the risk of harm to the child from removal from the home, balanced with the risk of repeat maltreatment to the child if the child remained in the home? Was there a big picture understanding of the child and family's strengths, protective capacities, hopes, needs, safety risks (including the risk of family violence), next life changes, transitions, and underlying issues that must change for the child to live safely and permanently with the family of origin or current resource family? *Assessing the Families needs is an ongoing process.*

ASSESSMENT CLARIFICATIONS

♦ Planning

- **Long-Term View:** Assess the Assessment outcomes: Substantiation leading to one of the following: Safety Plan with Ongoing Case management (In-home or Out-of-home), Family Support/ Community Services Plan (FS/CS) Plan with or without referral for Voluntary Services, No FS/CS Plan with referrals or No plans or referrals. Does the Outcome provide a vision for the family's independence of DCS that reflects the family's strengths, protective capacities, risk, barriers, needs and preferences? Is there a clear explanation of what needs to be in place or what changes need to occur to ensure the child's Safety and the family's independence of DCS with no repeat maltreatment. The team must have clarity and agreement of (1) the vision for sustainable, safe case closure; (2) the action steps needed; (3) prioritization by the family and team on where to begin in order to have an achievable long-term view. Would concurrent planning be effective in this case? Is there a concurrent goal?

- **Child/youth and Family Planning Process:** Assess the Plan/Intervention that was put in place. Were the plans and/or interventions relevant to the child and family's situation and/or needs? Was the plan and interventions based on a big picture understanding (accurate assessment of underlying needs including Domestic Violence and Mental Health issues) of the family or the immediate issues from the safety assessment? Did the plan include measurable goals to achieve behavior change necessary for sustainable, safe case closure? Were the strengths, protective capacities, and needs of the family addressed? Were the plans appropriate, current, and known to address safety issues? Were the plans based on a clear agreement of unified vision for sustainable, safe case closure?

- **Planning Transitions and Life Adjustments:** Was there an appropriate transition through a CFTM from assessment to ongoing case management? Was there appropriate communication between Family Case Managers (FCMs), between FCMs and families, FCMs and caregivers, as well as, FCMs and providers? How was the intervention process done? Was the transition plan done in a manner to improve the situation? Were plans made in order to transition the case effectively from Assessment FCM to the Ongoing FCM in a seamless transition for the family so the big picture understanding of the family and progress in the case was shared without loss of information? Did the transition minimize the losses the child experienced? If the child was placed with a relative, did a CFTM support the family in the process? Was there an appropriate sense of urgency in finding the right match for the child and involving the child and family in the decision process? Was the family involved in sharing information that would help the new placement care for the child? Did the child have to change schools? Was the school placement considered in the placement decision? If a transfer occurred, was the school transfer accomplished smoothly, with necessary supports if needed?

♦ Intervening

- **Intervention Adequacy:** For assessments that transition to ongoing case management, were the appropriate referrals made and which FCM (Assessment or Ongoing) starts the process? Was a plan in place and was there a shared vision of what sequence of services would be effective initially and did the services meet the cultural needs of the family through both the FCM and the providers? Did the services implemented help to achieve the measurable goals identified in the plan? Does the visitation plan address the emotional needs of the child in order to continue the bonding with their caregiver or create bonding opportunities during critical stages of development?

- **Resource Availability:** Were the resources available to the family and at the time that the family needed it? Was the family waiting for an extended period of time for services to begin or be referred? Did or would the timely availability of a particular services reduce the need for removal? Were services available locally?

- **Maintaining Quality Family Relationships:** If there was a removal, was the child removed during the Assessment? Were the important relationships to the child identified and was a visitation plan put in place to maintain those identified relationships (parent, siblings, and extended family including friends of the family, kinship, etc). Were maintaining these contacts seen as an immediate priority by the agency? Did the contact meet the needs of the child and family? Consider the age of the child and amount of time needed for continued bonding? Were visits and other forms of contact used when possible?

- **Tracking & Adjusting**: Prior to the assessment closing, were there any intervention strategies or plans that needed to be re-assessed and required change? Were there any follow-up on referrals and/or needed supports or changes to the Safety Plan or Family Support/Community Services Plan needed prior to assessment closure? Was the history of the family considered in order to adjust plans to transition the family forward towards sustainable changes and making a difference in the family situation?

OLDER YOUTH SERVICES CLARIFICATIONS

Indicators for Youth Status

♦ Safety Indicators

- **Safety:** To What degree: •Is the youth free from injury caused by others in his/her daily home, school, place of employment, and community settings: **[past 30 days]**
  - Are there people living and/or visiting with the youth (with or without a protective order in place) that compromise the youth's safety?
  - Does the youth's community or living arrangement pose a threat to their safety through criminal activity by self or others?
  - Are their ongoing conversations with the youth by essential connections, therapist, or others in order for youth to avoid activities and/or situations that place the youth at risk, such as unsafe sex, self-injuring behaviors, allowing unscrupulous people access to their home or to live in the home, domestic violence incidents, not treating mental health diagnoses, eating disorders, etc?
  - Assess youth based on their age and functioning capacities in relation to capability and development.

- **Behavioral Risk to Self/Others:** To what degree: •Is the youth consistently avoiding self-endangering situations and refraining from using behaviors that may put him/herself or others at risk of harm? **[past 30 days]**
  - If drug ro alcohol abuse has been identified, is there a relapse prevention plan in place or ongoing discussions with a therapist, another professional, or support group (i.e., NA, AA) taking place to identify coping strategies?
  - Are there ongoing conversations with the youth by their identified essential life-long connection(s), therapist(s), or other professionals in order for youth to avoid participating in or continuing participation in risky behaviors, such as unsafe sex, self-injuring behaviors, allowing unscrupulous people access to their home or to live in their home, domestic violence incidents, not treating mental health diagnoses, eating disorders, etc?
  - Assess youth based on their age and functioning capacities in relation to capability and development.

♦ Permanency Indicators

- **Stability:** To what degree: • Is the youth's daily living, learning, and work arrangements stable and free from risk of disruption? Is the youth's daily setting, routines and relationships consistent? Are known risks being managed to achieve stability and reduce the possibility of future disruptions? **[Timeframe: past 12 months and next 6 months]**
  - Does the youth have a sponsor and does the youth contact the sponsor, when appropriate, to utilize them for prevention of drug or alcohol relapse? Does the youth continue treatment, as appropriate, and attend AA/NA routinely?
  - Does the youth maintain contact with and utilize their identified essential life-long connection(s) for emotional support, financial supports, resource supports, etc?
  - Is the youth able to sustain the same employment, affordable housing, medical treatment, mental health services, and maintain having no criminal involvement?
  - The youth does not allow unscrupulous people to take advantage of them emotionally, financially, behaviorally, etc? Are the youth's housing, employment, supports, finances, etc., impacted by unscrupulous people or their influence on the youth?
  - Does the youth have an identified essential life-long connection?
  - Assess youth based on their age and functioning capacities in relation to capability and development.

  Note: Planned transitions such as college housing changes, including those during break periods, do no qualify as disruptions.

- **Permanency/Successful Adulthood:** To What degree: • Is the youth able to sustain themselves without agency involvement, utilizing supports and services identified while involved? Has the youth developed a plan that will endure? Have identified risks been eliminated? Is the youth's stability sustainable for a period of time? Are youth and the team aware of the action steps needed for youth to maintain without DCS involvement? **[past 30 days]**
  - Is the youth knowledgeable about their own services that they receive, have long-term affordable housing goals, able to meet their transportation needs, and have knowledge of and access to community services to support their long-term success?
  - Does the youth have and implement vocational, educational, and employment goals, as well as plans to sustain themselves?
  - Does the youth have and utilize an identified essential life-long connection?
  - Does the youth find and access acceptable ways to meet basic living needs?
  - Assess youth based on their age and functioning capacities in relation to capability and development.

Notes: (1) Another Planned Permanent Living Arrangement (APPLA) is the permanency plan for all Collaborative Care Cases. (2) Alternative and/or concurrent permanency plans are not applicable for this case type. (3) If the youth is both working and attending school, there is no minimum work or school hour requirement. (4) The youth must be either working or attending school in this program.

OLDER YOUTH SERVICES CLARIFICATIONS

- **Appropriate Living Arrangement:** To what degree: •Is the youth living in the most appropriate setting that fosters, teaches, and supports the youth living independently without DCS involvement? **[past 30 days]**
    - The youth's setting should be consistent with their desires and/or abilities and also assist them in transitioning to live independently without DCS involvement.
    - If the youth is expected to exit the program within the next 6 months, the youth must have an identifiable plan to sustain themselves. The plan may include, **but should not be limited to,** community resources such as Temporary Aide to Needy Families (TANF) and food stamps, and should explore accessing voluntary Independent Living (IL) services and/or Education and Training Vouchers, Emancipation Goods and Services, and room and board funds.
    - Assess youth based on their age and functioning capacities in relation to capability and development.

  Notes: (1) Youth cannot live with biological or adoptive parents as part of this program. (2) Youth may reside in relative home (if they have known relatives) including with adult siblings. (3) Youth are always in out-of-home placement as part of the program. This may include an unlicensed host home, licensed foster home, college dorm, own apartment, or group home, etc.

- **Physical Health:** To what degree: •Is the youth achieving and maintaining his/her optimal health status? **[past 30 days]**
    - Does the youth have knowledge of sexual health that includes contraception, planned or unplanned pregnancies, and STDs?
    - Does the youth have knowledge of Medicaid assistance and what medical and mental health services are available? Does the youth have knowledge of the Medicaid eligibility process or open enrollment for private insurance? Are they able to obtain coverage timely and prevent lapses in their coverage?
    - Is the youth educated on who will make medical decisions for them in case of incapacitations or medical emergency (Advanced Directive)? Is the youth maintaining appropriate hygiene and self-grooming routines? Receiving medical and dental care annually or according to specific need? Does the youth maintain their medications as prescribed?
    - Assess youth based on their age and functioning capacities in relation to capability and development.

- **Emotional Status:** To what degree: •Is the youth presenting age-appropriate emotional development, adjustment, attachment, coping skills, and self-control? Is the youth achieving and maintaining an adequate level of behavioral functioning in daily settings and activities, consistent with age and ability **[past 30 days]**

  If drug or alcohol abuse has been identified, is there a relapse prevention plan in place or ongoing discussions with therapist(s), other professionals, or support groups (i.e. NA, AA) taking place to identify useful coping strategies? Are there discussions regarding a plan to avoid participating in risky behaviors, such as unsafe sex, self-injuring behaviors, not treating mental health diagnoses, eating disorders, etc?

  The youth does not allow unscrupulous people to take advantage of them emotionally, financially, behaviorally, etc.

  Assess youth based on their age and functioning capacities in relation to capability and development.

- **Learning and Development:** To what degree: •Is the youth enrolled in education and/or a technical education program? Is the youth engaged and achieving educational goals consistent with their abilities and projected career objectives? Is the youth regularly attending school? Reading at grade level or IEP expectations? Meeting requirements for promotion and course completion leading to a high school diploma or equivalent? **[past 30 days]**
    - Assess youth based on their age and functioning capacities in relation to capability and development.

  Note: If not enrolled in any educational setting, score this indicator not applicable (NA).

- **Pathway to Independence:** To what degree: •Is the youth gaining skills, education, work experience, connections, relationships, income, affordable housing, and necessary capacities for living safely and functioning successfully, independent of DCS involvement? Is the youth developing long-term connections and informal supports which will assist them throughout adulthood? **[past 30 days]**
    - Does the youth find and access acceptable ways to meet basic living needs?
    - Does the youth have vocational, educational, or employment goals? Have these goals been implemented in connection with the youth's desires and/or abilities to assist them in transitioning to live independently?
    - Assess the youth based on their age and functioning capacities in relation to capability and development.

  Note: Youth are required to be either working at minimum 80 hours monthly or be enrolled and participating in an education program. If the youth is both working and attending school, there is no minimum work hour requirement.

OLDER YOUTH SERVICES CLARIFICATIONS

- **Youth Parenting Capacities: (Score the youth only)** To what degree: •Is the youth demonstrating adequate parenting capacities on a reliable daily basis commensurate with what is required to provide their child(ren) with appropriate nurturance, guidance, protection, care, education, and supervision? If the child(ren) has special medical, emotional, behavioral, and/or developmental needs, does the youth have and use any special knowledge, skills, and supports that may be required to meet the needs of the child(ren)?
    - Score this indicator if the youth is a **custodial or non-custodial** parent.
    - If the youth and child are placed in the same home, such as a licensed resource home, relative home, host home, group home, or residential setting, the youth's parenting capacities are scored independent of the type of placement in which they live. Appropriate use of natural resources within the placement, such resource mother, relative, or friend as childcare options, does not necessarily negatively impact the parenting capacity score of the youth.
    - Assess youth based on their age and functioning capacities in relation to capability and development.

- **Informal Supports: (Score the youth only)** To what degree: •Is the youth engaged with a healthy, informal support system that assists them with essential daily living skills?
    - Does the youth identify and utilize informal supports?
    - Does the youth have opportunities to exchange experiences, strategies, and successes with others whom they have an essential life-long connection?
    - Assess youth based on their age and functioning capacities in relation to capability and development.

- **Parenting Capacities: Current-Caregiver**
    - Does the youth identify and utilize informal supports?
    - Does the youth have opportunities to exchange experiences, strategies, and successes with others whom they have an essential life-long connection?
    - Assess youth based on their age and functioning capacities in relation to capability and development.

- **Informal Supports: Current-Caregiver**
    - Score this indicator N/A if youth resides in own apartment, dorm, or shared housing.
    - Score this indicator when the youth lives in a resource home, host home, or relative home.

Indicators of Practice Performance

♦ Engaging

- **Role & Voice:** To what degree: • Does the youth have an appropriate, driving voice in the case? Are they active participants in case planning and identifying appropriate services? Is there a trust-based relationship with all team members?
    - Assess youth based on their age and functioning capacities in relation to capability and development.

Score the following:

- Youth (N/A option available if youth does not have the cognitive ability to exercise *any* role and voice in their case).
- Essential Connection (N/A option available).

♦ Teaming

- **Team Formation:** To what degree: • Have the people, who provide support and services for this youth, been identified and formed into a working team? Has the youth selected the persons on their team? Does the team have the skills, knowledge of the youth, and abilities necessary to organize effective services for the youth based on their complexity and cultural background? Is the youth driving their team? Does the team include at least one essential life-long connection for the youth?

- **Team Functioning:** To what degree: • Do members of the youth's team collectively function as a unified and coordinated team in planning services and evaluating results? Do actions of the youth's team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the youth?

♦ Assessing

- **Cultural Recognition:** Has the youth's and family's culture, values, and beliefs been identified, recognized, and addressed in practice related to sustainability in the areas of services, affordable housing, education, vocational goals, employment, etc?

- **Assessing & Understanding: (Score the youth only)** To what degree: • Does the team have a shared, big picture understanding of the youth's underlying issues, needs, strengths, protective capacities (if a parent), hopes, and safety risks that must change for the youth to safely live independently? Is there an ongoing situational awareness of the youth?

OLDER YOUTH SERVICES CLARIFICATIONS

♦ Planning

- **Long-Term View (LTV):** To what degree: • Is there an explicit guiding view for the youth that should enable them to live safely and successfully?
  - Is the youth knowledgeable about their own services that they receive, have long-term affordable housing goals, able to meet their transportation needs, and have knowledge of and access to community services to support their long-term success?
  - Assess youth based on their age and functioning capacities in relation to capability and development

- **Youth & Family Planning Process:** To what degree: • Is the planning process individualized and relevant to meet the youth's goals?
  - Are change strategies, interventions, and supports organized into a holistic and coherent service process that provides a mix of elements uniquely matched to the youth's situation and preferences as to maximize potential results and minimize conflicts and inconveniences?
  - Are the support networks and services around the youth viable, sustainable, and effective in achieving short-term and long-term results for youth independence?

- **Planning Transitions & Life Adjustments:** To what degree: • Does the youth have a current transition plan developed with the youth's voice, desires, goals, and objectives which are designed to transition the youth to live independently?
  - Does the transition plan have measurable, realistic, and attainable action steps to achieve the youth's goals and objectives?
  - Are upcoming transitions identified by the team and is there a plan in place to implement such transitions within a reasonable timeframe given the youth's abilities?
  - Assess youth based on their age and functioning capacities in relation to capability and development.

Note: Always score this indicator.

♦ Intervening

- **Intervention Adequacy:** To what degree: • Are the change-related interventions, actions, and resources provided to the youth of sufficient power (precision, intensity, duration, fidelity, and consistency) to enhance the youth's ability to sustain themselves?
  - If the youth is dependent on drugs and/or alcohol, are the interventions well-matched to the level of treatment needed?
  - Is an Intensive Outpatient Program (IOP) and/or support groups assisting the youth by addressing the underlying issues related to their drug usage, as well as options to prevent/address relapse?
  - Are Older Youth Services (OYS) working to address youth's sustainability in the areas of affordable housing, education, vocational goals, and employment? Are there other factors affecting the youth's short- and/or long-term sustainability?

- **Resource Availability:** To what degree: • Are formal supports services and resources necessary to implement planned change strategies available as required (i.e., timeliness, fit to the situation, and change strategy used, intensity, duration, locally accessible) for use by the youth?
  - Does the youth have access to affordable housing that the youth is able to maintain?

- **Tracking and Adjusting:** To what degree: • Does the team monitor the youth's progress, intervention process, and change outcomes to make necessary planning adjustments? Are strategies and services modified to respond to the changing needs? Is the knowledge gained about planned strategies and results applied to create adjustments to service processes in finding what works for the youth?

- **Maintaining Relationships:** To what degree: • Are specifically planned strategies and supports working to build and sustain family connections through appropriate visits and other means, unless compelling reasons exist for keeping them apart? Have strategies and efforts been put into place to support the following relationship between the youth and identified family for: (1) Building and maintaining positive interactions? (2) Creating and using opportunities for providing emotional support? (3) Using varied and creative opportunities for family members to nurture one another?

  Assess whether or not the youth allows unscrupulous family members to take advantage of them emotionally, financially, behaviorally, etc. Are the youth's housing, employment, supports, finances, etc., impacted by unscrupulous family members or their influence on the youth?

  Note: This indicator should be scored with the following guidelines:
  - *<u>Do not</u> score youth's biological or adoptive parents*
  - *Score siblings if the siblings are wards*
  - *Score non-ward siblings under Extended Family, if they are age 18 or older*
  - *Score N/A if there are safety issues for youth in having contact with the extended family*

CURRENT CAREGIVER/RESOURCE PARENT ADDITIONAL QUESTIONS

30. CURRENT CAREGIVERS/RESOURCE PARENT (Out of Home CHINS not in congregate care)

Resource parents: **are defined as related or non-related caregivers who have been given responsibility for care of the child by the agency while the child is under the placement and care responsibility and supervision of the agency. This includes pre-adoptive parents if the adoption has not been finalized.**

Assessing and Understanding [Last 90 Days/Past 12Months]

During the period under review, did the agency adequately assess the needs of the resource parents on an ongoing basis (with respect to providing services they need to ensure placement of the child(ren) in their home as well as provide care and supervision to ensure the safety and well-being of the children in their care)?

- Resource parent
  - Score N/A if:
    - The child(ren) have not been in any out-of-home placements for the **ENTIRE** last 90 days/past 12 months.
    - The child has been adopted and was with the pre-adoptive family for the **ENTIRE** past 12 months.
  - Score Yes if:
    - Continuous/On-going assessment of each Resource Parents' needs have been occurring for last 90 days/past 12 months.

Protocol Guidance:

- **All** resource parents, who cared for the child during the period under review, are included in this assessment.
  - ♦ If the adoption was finalized, but the child has been with multiple families during the past 12 months, this item should be scored for the 12 month question.
- Determine whether an assessment was conducted to identify what the resource parents needed to enhance their capacity to provide appropriate care and supervision to the child in their home, such as respite care, tutoring, assistance with transportation, or counseling to address the child's behavior problems.
- Determine whether assessment of resource parent needs is done on an ongoing basis. If there is no evidence in the case file that the agency assessed the needs of the resource parents at any time during the period under review, and the resource parents (if available for interview) indicate that they have not been assessed then the answer is no.

Intervention Adequacy

During the period under review, were the resource parents provided with appropriate services to address identified needs that pertained to their capacity to provide appropriate care and supervision of the child(ren) in their care?

- Score N/A if:
  - The child has not been in any out-of-home placements for the **ENTIRE** last 90 days/past 12 months.
  - The needs were assessed but no service needs were identified for the **ENTIRE** last 90days/past 12 months.
- Score Yes if:
  - Interventions were put into place to address the needs of the resource family to assist in preventing placement disruption for the **ENTIRE** last 90 days/past 12 months.

Protocol Guidance:

- **All** resource parents, who cared for the child during the period under review, are included in this assessment.
  - ♦ If the adoption was finalized, but the child has been with multiple families during the past 12 months, this item should be scored for the 12 month question.

CFSR ADDITIONAL QUESTIONS

Please determine Yes, No, or N/A for the following compliance questions
Please ensure you answer for both the last 90 day/past 12 months

Timely Initiation (Assessments, In-home cases, Foster Care (FC) Cases)

1. All assessments were initiated **(Safety)** in a timely manner based on policy?

Score N/A If:
- All reports on any child(ren)/youth living in the home were screened out.
- No reports of AB/NE received on any child(ren)/youth living in the home in the last 90 days/past 12 months.

Protocol Guidance:
You will score this indicator if there were any screened in reports for assessment on any child(ren)/youth in the home, over the last 90 days/past 12 months, regardless of the substantiation decision. All screened in reports require timely initiations.
It is important to make the distinction between fully initiated and response time. If an FCM responded in the appropriate timeframe, it does not necessarily mean that the FCM fully initiated the assessment. If an FCM responded, and was unsuccessful in making contact with the alleged victim or with another person who could speak to the condition of the child(ren)/youth (other than the perpetrator), the assessment was not fully initiated.

Concerted efforts refer to:
- When it is not possible or practical to complete timely initiation due to extenuating circumstances, DCS will document the extenuating circumstances and good faith efforts. If initiation/services were provided by another public state or local agency, such as law enforcement, the actions of those agencies may be beyond the control of DCS and would not be considered untimely initiation.

Score Yes if:
- Face-to-face contact was made with the alleged victim **OR** contact was made with another person (other than the alleged perpetrator) who could provide information on the allegations and conditions of the child(ren)/youth. FCM notified the parent, guardian, or custodian in person or via phone, of the face-to-face contact with the alleged victim(s). DCS Initiation Policy: (DCS Policy 4:38)

Score No if:
- All criteria under "yes" were not achieved.

Pre-placement/Re-entry Placement Services: (Assessments, In-home cases, FC cases where child/youth has been reunified within the last 90 days/past 12 months, and FC cases where the child has entered foster care within in the last 90 days/past 12 months)

2. Did the system make concerted efforts to offer services **(Planning)**, when deemed appropriate, to ensure the children/youth's safety to prevent them entering or re-entering FC?

Score N/A If:
- No safety issue for any child(ren)/youth who were in the home.
- A safety plan was the only provision needed to ensure the child(ren)/youth's safety rather than safety-related services.
- Focus child/youth came into foster care for delinquency or dependency/safety concerns not related to the parents' AB/NE. (Ex: Children's Mental Health Initiative)
- The removal was an emergency situation necessary to ensure the focus child/youth's safety.
- Focus child/youth is in FC and entered more than last 90 days/past 12 months.

Protocol Guidance:
Services are those, which related to the prevention of immediate removal and re-entry of the child(ren)/youth into FC. Appropriate services were provided to, or arranged for, the family with the explicit goal of ensuring the child's safety. In most cases a child/youths' need for mental health services, education-related services, or services to address health issues, would not be considered relevant to the child/youth's safety, if the child/youth remained in the home.

CFSR ADDITIONAL QUESTIONS

Concerted efforts refer to:
Agency facilitated a family's access to needed services and worked to engage the family in those services**.**
Focus only on whether the agency made **concerted efforts** to provide appropriate and relevant services to the family to address the safety issues in the family so that the child(ren)/youth could remain safely in the home or would not re-enter FC after reunification.

Examples include:

- if there are safety issues in the home due to environmental hazards, homemaking services could be an appropriate safety-related service;
- if there are safety concerns related to the parent's ability to manage specific child needs or child behaviors, intensive in-home services could be an appropriate safety-related service;
- child care services could be a safety-related service in cases where the child was being cared for in an unsafe setting or by an inappropriate caregiver; and
- if there are safety concerns related to parental substance abuse, substance abuse treatment could be an appropriate safety-related service

Score Yes If:

- Services were provided for the family of child(ren)/youth, at risk for FC placement, to remain safely in their home which prevented removal or re-entry into FC.

Score No If:

- All criteria under "yes" were not achieved.

Safety Plans: (Assessments, In-home cases, FC child/youth who have been in the family home at some time within the last 90 days/past 12 months, or FC child/youth and there are other children residing in the family home)

3. If there were safety concerns from others, did the family team (including DCS) develop an appropriate safety plan **(Planning)** and did the team continually monitor **(Tracking)** and update **(Adjusting)** the plan?

Score N/A If:

- There were no safety concerns from others for the focus child/youth or any other child(ren)/youth in the home during the last 90 days/past 12 months.
- If the focus child/youth remained in FC during the last 90 days/past 12 months and no other child(ren)/youth remained in the home.

Protocol Guidance:
Score when the focus child/youth:

- Has returned home in the last 90 days/past 12 months.
- Is on Trial Home Visit (THV).
- Has never been removed.
- Is out of the family home but other children reside in the home.

Appropriate **safety plans** addressed the following components:

- Safety threats and how those were managed by caregiver(s).
- Caregiver's capacity to implement the plan and report safety issues to the agency.
- Family involved in implementation of the plan.

Score Yes if:

- A written plan existed, and interviewees reported:
  - Who participated in the implementation of the safety plan, and
  - Team members were able to articulate the plan and how the plan was continually monitored and updated for the safety needs of all the children/youth in the home.
  - All components identified and incorporated into the plan to ensure safety of child(ren)youth.
  - Caregivers knew the plan and implemented the safety plan as designed.

Score No If:

- All criteria under "yes" were not achieved.

CFSR ADDITIONAL QUESTIONS

Safety Concerns For Any Child/Youth in the Family Home (Assessments, In-home cases, FC child(ren)/youth who have been in the family home at any time within the last 90 days/past 12 months, or FC child(ren)/youth and there are other children residing in the family home)

4. Were all safety concerns **(Safety)** pertaining to any child/youth who remained in the home adequately or appropriately addressed?

Score N/A If:

- There were no safety concerns from others for the focus child/youth or any other child(ren)/youth in the home during the last 90 days/past 12 months.
- If the focus child/youth has remained in foster care in the last 90 days/past 12 months and no other child(ren)/youth remained in the home.

Protocol Guidance:
Score when the focus child/youth:

- Has returned home in the last 90 days/past 12 months.
- Is on Trial Home Visit (THV).
- Has never been removed.
- Is out of the family home, but other children remained in the family home.

Score Yes If:

- **Recurring maltreatment**: There was at least one substantiated maltreatment report on any child/youth in the family during the last 90 days/past 12 months **AND** there was another substantiated report within a 6-month period **before or after that report** that involved the same or similar circumstances. In determining the similarity of the circumstances, consider the perpetrator of the maltreatment and other individuals involved in the incident.

- **Recurring safety concerns**: There was at least one maltreatment report that involved any child/youth in the home during the last 90 days/past 12 months, which resulted in opening a case for services to address those safety concerns. In addition, there was at least one additional maltreatment report within a 6-month period **before or after that report** that which resulted in a decision to open a new case for services to address the same or similar safety concerns. In determining the similarity of the concerns, consider the perpetrator of the maltreatment, other individuals involved in the incident, and the type of safety issues that existed.

- The case closed while **significant safety concerns were not adequately addressed** still existed in the home.

Score No If:

- All criteria under "yes" were not achieved:

Safety Concerns Related to Visitations (FC Cases Only)

5. Was there sufficient monitoring to ensure safety concerns **(Safety)** related to visitations **(Planning)** between parents, caregivers, other family members and child(ren)/youth did not occur **(Assessing)**?

Score N/A If:

- Focus child/youth was not in Foster Care during the last 90 days/past 12 months.
- Focus child/youth resides in custodial/non-custodial home.
- Focus child/youth did not have any visitations within the last 90 days/past 12 months.

Protocol Guidance:
Determine the quality of initial and ongoing assessments, evaluate whether there were any safety concerns present during visitation in the last 90 days/past 12 months, and whether DCS responded appropriately to all safety concerns.

Score Yes If:

- Sufficiently monitored visitation by parents/caretakers or other family members was ensured.
- Visitations were appropriately supervised when deemed necessary.
- Visitation was court-ordered without any safety concerns by the team members
- There were safety concerns related to the child/youth's foster care placement during the last 90 days/past 12 months.

Score No If:

- All criteria under "yes" were not achieved.

Quality of Contacts Between FCM/Child/Youth/Family (Assessments, In-home cases, FC Cases)

6. Was the ***frequency*** of contacts between FCM and child(ren)/youth, and parents sufficient to address issues pertaining to safety, permanency, and well-being of the child(ren)/youth and promote achievement of case goals?

Mother/Father Protocol Guidance:

Score N/A If:

- Parental rights have been terminated for the past 12 months. If TPR occurred within the last 12 months the 90 day section is scored N/A but the 12 month section should still be scored.
- Whereabouts of parent was unknown during the last 90 days/past 12 months despite DCS utilizing all resources to locate the mother and/or father.

A "contact" is defined as a face-to-face contact between caseworker and mother/father. Score only the FCM's contact with the mother/father. Determine the most typical pattern of contacts over the last 90 days/past 12 months because the actual frequency may vary in specific time periods according to the federal guidelines and state policy -DCS Minimum Contact Policy (DCS Policy 8.10)

Concerted efforts refer to**:**
Typically, at least monthly contacts are required; but, they should be determined based on the circumstances of the case and needs of the child(ren)/youth, as well as federal guidelines and state policy. In some instances, monthly contacts may be difficult to achieve and maybe prevented in situations where other systems might not permit them, such as placements or viable facilities are out-of-state, or parent(s) may live out-of-state. In lieu of face-to-face FCM contacts, FCMs efforts to maintain monthly communications with the parent(s) via phone calls and/or letters should be considered.

Score Yes If:

- FCM's frequency of contact with Mother/Father met state and federal guidelines (at least monthly) and met minimum service level contact standards (see below) unless there is substantial justification for less frequent visits, which could vary depending on the circumstances of the case
    - Minimum Service Level Contact Standards
        - DCS will have face-to-face contact with the child's parent or guardian according to the following minimum service level contact standards:
            - 1. Low service level case - DCS will have one (1) face-to-face contact per month with the child's parent, guardian, or custodian in their residence;
            - 2. Moderate service level case - DCS will have two (2) face-to-face contacts per month with the child's parent, guardian, or custodian with one (1) contact being in their residence. One (1) of the two (2) contacts can be designated to a service provider;
            - 3. High service level case - DCS will have three (3) face-to-face contacts per month with the parent, guardian, or custodian with one (1) contact being in their residence. Two (2) of the three (3) contacts can be designated to a service provider; and
            - 4. Very High service level case - DCS will have four (4) face-to-face contacts per month with the child's parent, guardian, or custodian with two (2) contacts being in their residence. Three (3) of the four (4) contacts can be designated to a service provider.

Score No If:

- All criteria under "yes" were not achieved.

Child(ren)/Youth Protocol Guidance:

You will **always** score this indicator for the child(ren)/youth, over the last 90 days/past 12 months. A "contact" is defined as a face-to-face interaction between FCM and child(ren)/youth. If the case in an in-home service case then this is rated for all the children who are living in the home or receiving services through the agency. If the case is a foster care case, then only answer for the only focus child/youth. Score only the FCM's contact with the child(ren)/youth.

CFSR ADDITIONAL QUESTIONS

Determine the most typical pattern of contacts during the last 90 days/past 12 months because the actual frequency may vary in specific time periods according to the federal guidelines and state policy-DCS Minimum Contact Policy (DCS Policy 8.10)

Concerted efforts refer to**:**
Typically, at least monthly contacts are required; but, contact should be based on the frequency necessary to ensure the child/youth's safety, permanency and well-being and not on compliance with state policy requirements regarding FCM contacts with child/youth. When the child/youth or resource family is in crisis,visitation must be made weekly by the assigned Family Case Manager (FCM). The FCM will monitor and evaluate the situation as well as convene the Child and Family Team (CFT), to assess whether the situation warrants continued weekly visits. (DCS Policy 8.10)

Score Yes If:
- FCM's frequency of contact ensured the child(ren)/youth's safety and promotion/progression of achievement of case goals that included safety planning.
- FCM met minimal federal guidelines(monthly) and state policy -DCS Minimum Contact Policy (DCS Policy 8.10)—at least monthly, unless more contacts were required to address safety, permanency, and well-being of the child/youth and promote achievement of case goals.

Score No If:
- All criteria under "yes" were not achieved.

Quality of Contacts Between FCM/Child/Youth/Family (Assessments, In-home cases, FC Cases)

7. Was the ***quality*** of contacts between FCM and child(ren)/youth and parents sufficient to ensure safety, promotion/progression, and of achievement of case goals?

Mother/Father Protocol Guidance:

Score N/A If:
- Parental rights have been terminated for the past 12 months. If TPR occurred within the last 12 months the 90 day section is scored N/A but the 12 month section should still be scored.
- Whereabouts of parent was unknown during the last 90 days/past 12 months despite DCS utilizing all resources to locate the mother and/or father.

A "contact" is defined as a face-to-face contact between caseworker and mother/father. Score only the FCM's contact with the mother/father.

Concerted efforts refer to**:**
Typically, at least monthly contacts are required; but, they should be determined based on the circumstances of the case and needs of the child(ren)/youth, as well as federal guidelines and state policy. In some instances, monthly contacts may be difficult to achieve and maybe prevented in situations where other systems might not permit them, such as placements or viable facilities are out-of-state, or parent(s) may live out-of-state. In lieu of face-to-face FCM contacts, FCMs efforts to maintain monthly communications with the parent(s) via phone calls and/or letters should be considered.

Score Yes If:
- Contact with Mother/Father met state and federal guidelines (at least monthly) and met minimum service level contact standards unless there is substantial justification for less frequent visits, which could vary depending on the circumstances of the case.
- FCM met with Mother/Father separately from each other and child(ren)/youth.
- Contacts were used to update safety plans and to initiate, assess, and address safety threats/concerns to all child(ren)/youth in the home or in out-of-home care.
- Contacts included discussions about safety and promotion/progression of achievement of case goals.
- Contacts evaluated and addressed whether there were any safety concerns present during visitations.

Score No If:
- All criteria under "yes" were not achieved.

CFSR ADDITIONAL QUESTIONS

Child(ren)/Youth Protocol Guidance:

You will **always** score this indicator for the child(ren)/youth, over the last 90 days/past 12 months. A "contact" is defined as a face-to-face interaction between FCM and child(ren)/youth. If the case in an in-home service case then this is rated for all the children who are living in the home or receiving services through the agency. If the case is a foster care case, then only answer for the only focus child/youth. Score only the FCM's contact with the child(ren)/youth.

Determine the most typical pattern of contacts during the last 90 days/past 12 months because the actual frequency may vary in specific time periods according to the federal guidelines and state policy-DCS Minimum Contact Policy (DCS Policy 8.10)

Concerted efforts refer to**:**
Typically, at least monthly contacts are required; but, contact should be determined based on the circumstances of the case and needs of the child(ren)/youth, as well as federal guidelines and state policy. When the child/youth or resource family is in crisis, visitation must be made weekly by the assigned Family Case Manager (FCM). The FCM will monitor and evaluate the situation as well as convene the Child and Family Team (CFT), to assess whether the situation warrants continued weekly visits. (DCS Policy 8.10)

Score Yes If:

- Contacts were of sufficient time to address key issues with child(ren)/youth.
- Location of the contacts were conducive to the child(ren)/youth having an open and honest conversation with FCM.
- Child(ren)/youth were seen alone by FCM for at least part of the contact without parent(s) or resource parent(s) present (not applicable for infants).
- FCM addressed issues pertaining to the child(ren)/youths' needs, services, and case goals.
- Contacts were used to update safety plans and to initiate, assess, and address safety threats/concerns to child(ren)/youth.
- FCM's frequency of contact ensured the child(ren)/youth's safety and promotion/progression of achievement of case goals that included safety planning.
- Contacts evaluated and addressed whether there were any safety concerns present during visitations.
- FCM met minimal federal guidelines(monthly) and state policy -DCS Minimum Contact Policy (DCS Policy 8.10).

Score No if:

- All criteria under "yes" were not achieved.

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EXAMPLES OF SOLUTION-FOCUSED QUESTIONS

Listed below are some solution-focused questions. These were found to be quite useful in the review process and as you can see, you will need to use them according to the person being interviewed. The use of solution-focused questions allows you to learn a lot of information without asking too many questions. For the most part, each question you ask is dependent upon what the person has answered in regard to your last question. This list is not exhaustive by any means. Closed questions are also important at times.

SAFETY

"What is your biggest worry (or concern) about this family?" or with family members, including some children "What is your biggest worry?" These questions, as most all of the others, need to be "set up". For example, I might say to a case manager, I know that you are concerned about all your families. If you woke up in the night and started to think about his child and his/her family, what would be your biggest worry?

"As you think back over the difficult times in your life, who or what helped you through them?"

"If you had to put a plan together right now, what would be needed to safely close this case?"

TEAMING

To what extent does the child's therapist involve you in the development of the treatment plan?" "To what extent are you kept informed of progress?" These could be used with case managers as well as family members.

"Who else cares about this child/family?" This gives us information about the support system. It is especially good to ask the case manager, caregivers and providers and then compare their answers to that from the family members.

"Who would you put on this family's team?" "What does your family do for fun?" This might reveal the degree of knowledge about the formal and informal support system.

ENGAGEMENT

"Help me understand about how the final decision for TPR was reached." You can plug in any decision, of course.

"How did this child become known to the agency?" "Help me understand what brought this child into the system." "Tell me how you became involved with this family."

"If we could go back to the time when this family first entered our system, what do you think we could have done differently that would have been better for them?" Or a variation for the family…

"Have you ever had the opportunity to attend a child and family team meeting?" If so, "Do you remember what was discussed?" "Who attended?" "To what extent were you asked for input?" "In your opinion, whose meeting was that?" (Here you might have to explain just what a CFTM is—belongs to family, they do the invitation list, etc. - much different than a staffing).

"How often are you able to visit the child?" Good to use with GALS and case managers.

CULTURAL RECOGNITION

"Describe your family traditions (birthdays, holidays, family activities)."

"What are your family routines?"

"What is your understanding of the family's traditions?"

"How have the people you are working with been sensitive to your family's beliefs and traditions?"

PLANNING AND ASSESSMENT

"What is your biggest worry (or concern) about this family?" or with family members, including some children "What is your biggest worry?" These questions, as most all of the others, need to be "set up". For example, you may ask:

"What is your thinking about why the child does not want to return home?"

"Help me understand what the therapist is working on?" This might reveal if underlying needs are being addressed and it will give a general picture of how much is really known about the child/family and the degree of communication among all.

"What are the child's transition needs?"

"To what extent were you able to participate in the development of the permanency plan?"

"What do you believe are Ms._____'s underlying needs?" (Help the person to keep this separate from the services).

"Have you ever had the opportunity to attend a child and family team meeting?" If so, "Do you remember what was discussed?" "Who attended?" "To what extent were you asked for input?" "In your opinion, whose meeting was that?" (Here you might have to explain just what a CFTM is—belongs to family, they do the invitation list, etc. – much different than a staffing).

"How often are you able to visit the child?" Good to use with GALS and case managers.

"You have told me this child has some anger issues. Can you think of a time when he was not angry? What do you believe happened to cause the anger?" This is an exception finding question. Many times a family member can identify the point in time when things got bad…like his anger started when his father promised to visit and didn't and he never contacted his child again….

"What is the focus of your therapy sessions currently?"

"What have ___ (child/parent) identified they want to get out of their therapy sessions?"

EXAMPLES OF SOLUTION-FOCUSED QUESTIONS

"What would a typical day with you and your child be like?"

"If things could be better tomorrow, what would tomorrow look like?"

"What is the one thing that would be the most helpful to you?"

LONG-TERM VIEW

"What will it take for this child (or family) to live without DCS?" This will get a lot of information about the long-term view.

If the case manager tells you that she/he is ready to close the case you might ask…"If you close this case, do you think you will see this family back in the system?"

SCHOOL

"I have read in the record that this child has some behavior issues. Can you describe for me what his behaviors are in your classroom?" "I understand he has good days and bad days. Can you think of what might be going on during the bad days?"

INFORMAL SUPPORTS

"Who else cares about this child/family?" This gives us information about the support system. It is especially good to ask the case manager, foster parent and providers and then compare their answers to that from the family members.

"Who do you call (or talk to) when you feel good (or bad)?" "Who do you call if you need anything? If a person says that they cannot think of anyone who cares about them or their family you might try: "If your car broke down on the interstate, who would you call to help you?" or "Who do you spend holidays with?" You get the picture…

GENERAL QUESTIONS

"You mentioned that you had some concerns with….Please tell me about them."

"It sounds like you are saying…" This is a way to summarize and gives the person you are interviewing knowledge that you are listening (the most important interpersonal helping skill and the hardest to do!).

"Tell me about your relationship with…"

I would reserve the use of the miracle question until you establish a rapport with the one being interviewed.

"And how did that affect you/the child/your family?"

PARENT AND CHILD/YOUTH QUESTIONS

"Tell me how you are involved in the lives of your children?"

"On a scale of 1-10, how safe do you think this child/youth is?" One being very unsafe and 10 being the most safe she could be.

If the answer is say, a 7, then you might ask what could happen to make that an 8.

"With all the transition and change taking place in your life right now, what is the one thing that will sustain you?"

"If you could have 3 wishes, what would they be?" Be careful with children that you explain that you do not have the power to grant wishes.

"Tell me about the good things that have happened over the past year?" Good to ask of children.

INDICATORS OF TYPICAL DEVELOPMENT
AGES 1 – 3 YEARS

The purpose of this information is to orient testers to toddler development across all domains: cognitive, social, emotional, behavioral, physical, functional ("self-help"), and communicative. If you are familiar with typical toddler development through academic preparation or work experience, you probably don't need to read this section. On the other hand, if your experience is limited to personal acquaintance with a couple of toddlers or less, this information should give you some yardstick against which to compare the development of toddlers who are the focus of service testing. Any description of expected development is subject to the vagaries of individual development. Babies achieve developmental milestones in idiosyncratic ways: both the sequence and timing of specific milestones will vary. For this reason, the descriptions below are somewhat conservative: a child not reaching the milestones by the listed age is probably delayed, although children's behavior will predictably regress when they are under stress such as birth of a sibling, absence of a parent who usually lives with the child, etc. Another caveat: only a few indicators (or milestones) of development are listed here. They are those frequently used by professionals and listed in developmental literature, but there are many aspects of development not described here.

Note on Communication: Communication is often broken down into receptive language (the child understands when spoken to) and expressive language (speech). Expressive language can be further divided into speech (articulation or the ability to produce speech sounds) and language (using words and combinations of words with an understanding of their meaning). Note that if the child/ is raised in a bilingual environment, speech acquisition may be somewhat slower than the guidelines below indicate.

12 Months

Physical Development

- ☐ Most can walk, but may be unsteady.
- ☐ Uses a cup.
- ☐ Uses thumb and forefinger to pick up small objects
- ☐ Cooperates briefly with dressing.
- ☐ Explores objects in other ways than mouthing them (e.g. rolls objects with wheels, tries to open containers)
- ☐ Plays peek-a-boo, imitative games
- ☐ Plays 2- 3 minutes with a single toy.
- ☐ Finds an object she sees you hide from her.
- ☐ Guides an action toy manually; e.g. pushes car.

Expressive Language

- ☐ Babbling has both long and short groups of sounds such as "tata upup bibibibi".
- ☐ Uses speech or non-crying sounds to get and keep attention.
- ☐ Has one or two words ("uh-oh", "bye-bye", "dada", "mama", "no"), although they may not be clear.
- ☐ Responds appropriately to several words and understands simple commands combined with gestures.

Socio/Emotional Development

- ☐ Attached to primary caregiver and other family members; can discriminate between people.
- ☐ Develops fears of strangers at 6-9 months; this is much less intense by 10-12 months, when it looks more like shyness.
- ☐ Develops separation anxiety when separated from primary caregiver, especially in an unfamiliar environment, by 10 months; decreases by 18-24 months.
- ☐ Communicates wants and feelings through intentional gestures and facial expressions. Gestures and communications are increasingly elaborate and developed.
- ☐ Explores environment and toys actively.
- ☐ Soothes self when upset: e.g. by burrowing his/her face in favorite blanket or climbing on mom's lap.
- ☐ May have first tantrums.

Pre-Literacy Skills

- ☐ Looks at pictures for one minute when objects are names.

24 Months

Physical Development

- ☐ Jumps with two feet off the ground.
- ☐ Walks up stairs holding wall or rail, both feet on each step.
- ☐ Walks downstairs, putting both feet on each stair, with hand held.
- ☐ Kicks a ball.
- ☐ Stacks several blocks.
- ☐ Can take off most clothes, put on some.

Cognitive Development

- ☐ Recognition that objects/people continue to exist when out of sight; e.g. secure when caregivers walks into the kitchen, not surprised when she returns.
- ☐ Begins to see simple cause/effect relationships, and acts deliberately to cause effects; activates mechanical toy.
- ☐ Uses objects as tools; e.g., uses one block to push another one.
- ☐ Learns properties of objects (how things feel, sound, look, taste, smell); e.g., smells flowers, shakes ball with hidden bell.
- ☐ Tires to figure out how things work: looks under a toy that moves, etc.
- ☐ Simple pretend play: "pours: from empty pitcher, etc.

Expressive Language

- ☐ Understands more than she expresses.
- ☐ Says more words every month.
- ☐ Uses some two word questions ("Where kitty?", "Go bye-bye?", "What's that").
- ☐ Puts two words together ("more cookie", "no juice", "mommy book").
- ☐ Says at least 50 words.

INDICATORS OF TYPICAL DEVELOPMENT
AGES 1 – 3 YEARS

Social/Emotional Development
- ☐ Toddlers start to use words to express their wants and needs; they have a range of emotional expressions.
- ☐ Toddlers start to learn to regulate emotions (e.g., they don't always "lose it" when frustrated) and wait a short time for something they want.
- ☐ Toddlers start to learn to follow rules and social conventions, curb and redirect their aggression.
- ☐ Toddlers interact socially with peers and adults.
- ☐ Tantrums are common and may be loud and last five minutes.

Pre-Literacy Skills
- ☐ Enjoys looking at picture books with an adult, turns pages (may be awkward with paper pages), pointes to and names objects in pictures.

36 Months

Physical Development
- ☐ Can string large beads, use markers and large paint brushes; can brush her teeth.
- ☐ Jumps forward 2-3 feet.
- ☐ Can catch a large soft ball thrown directly to him/her.
- ☐ Tries to cut with scissors and write with markers but often uses incorrect grasp.
- ☐ Uses two hands together; e.g., to hold jar and unscrew lid.
- ☐ Copies a circle.
- ☐ Copies a three-block bridge.
- ☐ Alternates feet on stairs.

Cognitive Development
- ☐ Can think and talk about things that are not present.
- ☐ Can group similar objects (e.g., all red blocks or all cars) together.
- ☐ By age 36 months, child clearly knows his/her gender.
- ☐ Role plays ("I'm the daddy", "I'm the doctor").
- ☐ Can put together 3-4 piece puzzle.
- ☐ Can name 6-8 body parts.

Expressive Language
- ☐ Has a word for almost everything in familiar environment.
- ☐ Uses 2-3 word "sentences" to talk about and ask for things.
- ☐ Speech is understood by family most of the time.
- ☐ Interested in finger plays, rhymes.
- ☐ Uses "I".

Socio/Emotional Development
- ☐ Toddlers engage in their environment through elaborated play, using props/objects and including other people.
- ☐ Is aware of other people's thoughts and feelings; shows distress when others are upset or suffering.
- ☐ Independently attempts to solve problem (e.g., fix something that is not working) in a focused and persistent manner.
- ☐ Workers to manage a skill or task that is at least moderately challenging.
- ☐ Primary caregiver's attention and loving praise are powerful motivators.

Pre-Literacy Skills
- ☐ Enjoys listening to simple stories in picture books, points to and names objects in pictures.

36-48 Months

Physical Development
- ☐ Is toilet trained during the day except for infrequent accidents?

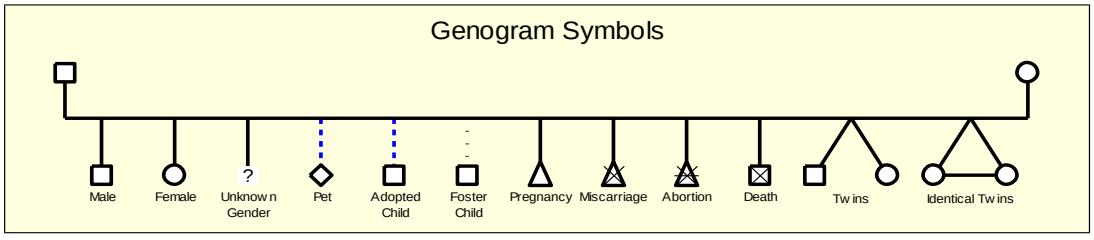
Cognitive Development
- ☐ Imagination develops, and with it, fantasies and fears.
- ☐ Can recall the past and anticipate the future.
- ☐ Asks lots of "why" questions.

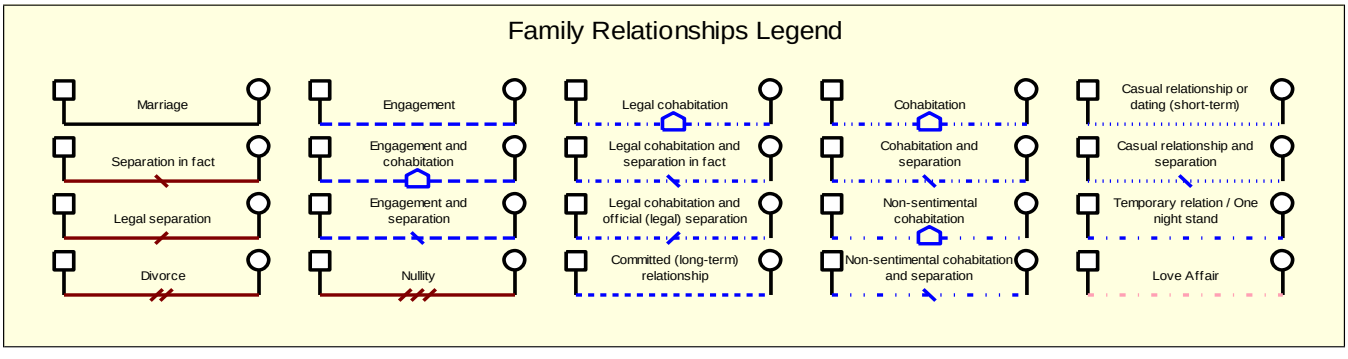
Expressive Language
- ☐ Talks about activities at child care, at friend's homes, or other activities outside the home.
- ☐ People outside the family usually understand child's speech.
- ☐ Uses a lot of sentences that have four or more words and usually puts words in correct order.
- ☐ Uses past and future tense pretty well.
- ☐ Uses language to express feelings and ideas (e.g., "When mommy gets home, we can have ice cream").

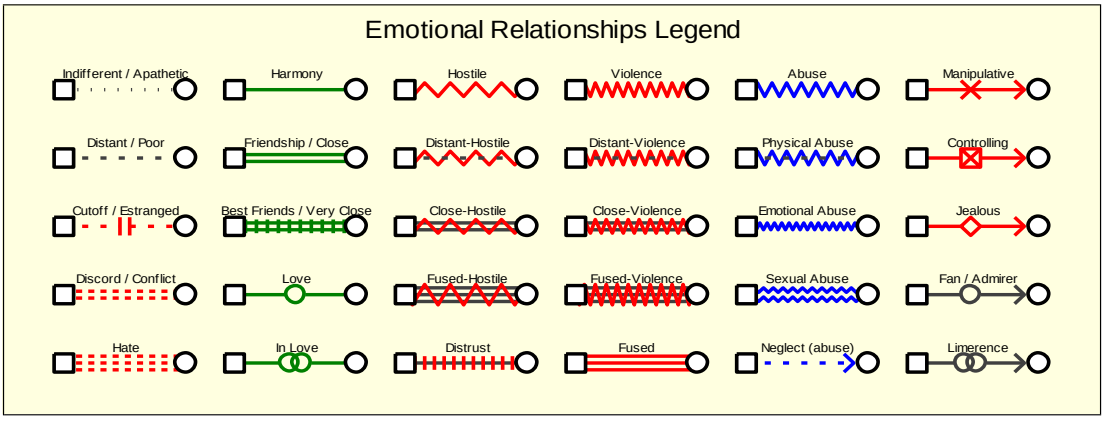
Socio/Emotional Development
- ☐ Begins to control own behavior rather than always needing an adult to control his/her behavior.
- ☐ By age 4, can sustain interactions with peers and play cooperatively.
- ☐ Tantrums are diminishing.

Pre-Literacy Skills
- ☐ Begins to understand the meaning of print; e.g., recognizes common signs and labels, asks adults to read printed words or pretends to read them him/herself.
- ☐ Experiments with a variety of writing-scribbles, drawings.
- ☐ Enjoys listening to stories with several lines of text per page.

GENO-PRO COMMON SYMBOLS KEY







ACRONYM GLOSSARY

The following are a list of acronyms commonly used in the Indiana Department of Child Services.

AAP	Adoption Assistance Program
ACF	Administration for Children & Families
ACLSA	Ansell Casey Life Skills Assessment
ADD	Attention Deficit Disorder
ADHD	Attention Deficit-Hyperactivity Disorder
ADI	Affidavit of Diligent Inquiry
AFCARS	Adoption and Foster Care Analysis and Reporting System
AG	Assisted Guardianship
AIDS	Acquired Immunodeficiency Syndrome
ALJ	Administrative Law Judge
APHSA	American Public Health Services Administration
APPLA	Another Planned Permanent Living Arrangement
ASFA	Adoption and Safe Families Act
BDDS	Bureau of Developmental Disabilities Services
BMV	Bureau of Motor Vehicles
CA/N	Child Abuse and/or Neglect
CAC	Child Advocacy Center
CANS	Child and Adolescent Needs & Strengths
CAPTA	Child Abuse Prevention and Treatment Act
CASA	Court Appointed Special Advocate
CAT	Computer Assisted Training
CCI	Child Caring Institution
CCWAR	Child Care Worker Assessment Review
CDS	Child Data Summary
CEU	Central Eligibility Unit
CFR	Code of Federal Regulations
CFSR	Children and Family Services Review
CFTM	Child and Family Team Meeting
CHINS	Child in Need of Services
CM	Case Management
CMPPA	Computer Matching and Privacy Protection Act of 1988
CPI	Child Protection Index
CPR	Cardiopulmonary Resuscitation
CPS	Child Protection Services
CPT	Child Protection Team
CTS	Counseling and Testing Sites
CW	Child Welfare
CWPPG	Child Welfare Policy and Practice Group
DCS	Indiana Department of Child Services
DEC	Drug Endangered Children
DFR	Division of Family Resources
DMHA	Division of Mental Health and Addiction
DNR	Do Not Resuscitate
DOC	Department of Corrections
DOE	Department of Education
EG&S	Emancipation Goods and Services
EMT	Emergency Medical Technician
ETV	Education and Training Voucher Program
FAFSA	Free Application for Federal Student Aid
FAKT	Foster Adoption Kinship Training
FBI	Federal Bureau of Investigation
FCM	Family Case Manager
FDA	Food and Drug Administration
FFA	Family Functional Assessment
FFH	Foster Family Home
FS/CS	Family Support/ Community Services Plan
FSSA	Family & Social Services Administration
GAL	Guardian ad Litem
GED	General Education Development
GH	Group Home
GPA	Grade Point Average
HAP	Hoosier Assurance Plan
HBV	Hepatitis B Virus
HCBS	Home & Community-Based Services
HCV	Hepatitis C Virus
HHS	Health & Human Services Administration
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HR	Human Resources
HSO	Human Systems and Outcomes, Inc
HSPP	Health Service Provide in Psychology
I&R	Information & Referral
IA	Informal Adjustment
I/A	Intake/Assessment
IAC	Indiana Administrative Code
IC	Indiana Code
ICES	Indiana Client Eligibility System
ICPC	Interstate Compact for the Placement of Children
ICU	Intensive Care Unit
ICWA	Indian Child Welfare Act
ICWIS	Indiana Child Welfare Information System
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan
IEPA	Inter-ethnic Placement Act
IFCAA	Indiana Foster Care & Adoption Assistance
IL	Independent Living
INS	Immigration and Naturalization Services
IOT	Indiana Office of Technology
IRB	Institutional Review Board
ISETS	Indiana Support Enforcement Tracking System
ISP	Indiana State Police
JD/JS	Juvenile Delinquent/Juvenile Status
LCPA	Licensed Child Placing Agency
LD	Learning Disabled
LEA	Law Enforcement Agency
LTV	Long Term View
MEPA-IEPA	Multiethnic Placement Act (1994)–Interethnic Adoption Provisions (1996)
MHST	Mental Health Screening Tool
MOU	Memorandum of Understanding
NAE	National Adoption Exchange
NICU	Neonatal Intensive Care Unit
NOA	Notice of Availability
NRAE	Non-Recurring Adoption Expenses
OYFC	Older Youth Foster Care
PDR	Predispositional Report
PI	Preliminary Inquiry
PIP	Program Improvement Plan
PPD	Parental Participation Decree
PPP	Petition for Parental Participation
PQI	Performance and Quality Improvement
QAR	Quality Assurance Review
QMHP	Qualified Mental Health Provider
QSR	Quality Service Review

ACRONYM GLOSSARY

R&B	Room and Board
RM	Regional Manager
RLU	Residential Licensing Unit
RTC	Residential Treatment Center
SACWIS	Statewide Automated Child Welfare Information System
SAS	State Adoption Subsidy
SCHIP	State Children's Health Insurance Program
SCR	State Central Registry
SED	Serious Emotional Disturbance
SFM	State Fire Marshall
SNAP	Special Needs Adoption Program
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
STD	Sexually Transmitted Disease
TANF	Temporary Assistance for Needy Families
TEAPI	Teaming, Engaging, Assessing, Planning, and Intervening
TFC	Therapeutic Foster Care
THV	Trial Home Visit
TLP	Transitional Living Placement
TPR	Termination of Parental Rights
U/D	Upload/Download
USC	United States Code
USCIS	United States Citizenship and Immigration Services
VSC	Voluntary Services Caseworker
YAB	Youth Advisory Board

Additional Helpful Hints
Emotional Status
Behavioral Risk
Long-Term View
Permanency
Child & Family Planning
Long-Term View
Assessing & Understanding